

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASBURY PLACE AT KING: B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2011
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT KINGSPORT		STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies There were no deficiencies noted on the day of this annual licensure survey.	N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

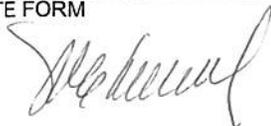
(X6) DATE

STATE FORM

6899

101121

If continuation sheet 1 of 1



V.P. of Operations, LHCA #3128

5-5-11

MAY 05 2011