

PRINTED: 01/21/2011  
FORM APPROVED

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>TN9003 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>01/20/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>ASBURY PLACE AT JOHNSON CITY | STREET ADDRESS, CITY, STATE, ZIP CODE<br>105 WEST MYRTLE AVENUE<br>JOHNSON CITY, TN 37604 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR 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 |
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| N 000 | <p>Initial Comments</p> <p>An annual licensure survey was completed on January 18-20, 2011, at Asbury Place at Johnson City. No deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.</p> | N 000 |  |  |
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| Division of Health Care Facilities<br><i>Melanie R. Scott, RN</i><br>LABORATORY DIRECTOR'S OF | PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Administrator</i> | TITLE<br><i>Administrator</i> | (X6) DATE<br>01.28.2011 |
|---|--|-------------------------------|-------------------------|