**Division of Health Care Facilities**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:** TN0805

**(X2) MULTIPLE CONSTRUCTION**

- **A. BUILDING:**
- **B. WING:**

**(X9) DATE SURVEY COMPLETED:** R-C 08/08/2012

**NAME OF PROVIDER OR SUPPLIER:** ASBURY PLACE AT MARYVILLE

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 2645 SEVIERVILLE RD MARYVILLE, TN 37804

<table>
<thead>
<tr>
<th>[X4] ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>[X8] COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>[N 000]</td>
<td>Initial Comments</td>
<td>[N 000]</td>
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<td>During a revisit survey at Asbury Place of Maryville on August 8, 2012, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.</td>
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C/O: #29957

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE**

**STATE FORM**

**STATE:** TN

**FORM:** 32JQ12

**DATE:** 08/08/2012