## A. BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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## B. WING MULTIPLE CONSTRUCTION

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## Statement of Deficiencies and Plan of Correction

**DATE SURVEY COMPLETED**: 07/17/2020

### Person Memorial Hospital

**STREET ADDRESS, CITY, STATE, ZIP CODE**: 615 Ridge Road, Roxboro, NC 27573

### Summary Statement of Deficiencies

### F 000 INITIAL COMMENTS

A complaint investigation was conducted from 07/15/2020 through 07/17/2020. Event ID# 52LK11. 3 of 3 complaint allegations were not substantiated.

### Provider's Plan of Correction

Each corrective action should be cross-referenced to the appropriate deficiency.

### Laboratory Director's or Provider/Supplier Representative's Signature

**DATE**: 08/13/2020

Electronically Signed

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.