POST-CERTIFICATION REVISIT REPORT												
IDENTIFIC	R / SUPPLIER / CI CATION NUMBER	MULTIPLE CONS [*] A. Building B. Wing									DATE OF REVISIT 7/14/2021	
345510			1				Y2	7/14/20	Z1 Y3			
NAME OF	STREET ADDRESS, CITY, STATE, ZIP CODE					CODE						
PRODIG	911 WESTERN BOULEVARD											
	TARBORO, NC 27886											
This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).												
ITEM			DATE	ITEM				DATE ITEM			DATE	
Y4			Y5	Y4			Y5 Y4				Y5	
ID Prefix	F0693		Correction	ID Prefix	F0761			Correction	ID Prefix	F0812		Correction
Reg.#	483.25(g)(4)(5) Complete		Completed	Reg. # 483.45(g)(h)		g)(h)(1)(2)	Completed		Reg.#	483.60(i)(1)(2)		Completed
LSC	06/04/2021		LSC				06/04/2021	LSC			06/04/2021	
ID Prefix	F0814		Correction	ID Prefix	F0880			Correction	ID Prefix			Correction
	483.60(i)(4)		_		483.80(a)(1)(2)(4)(e)	(f)					
Reg.#			Completed	Reg. #				Completed	Reg.#			Completed
LSC			06/04/2021	LSC				06/07/2021	LSC			
ID Prefix			Correction	ID Prefix				Correction	ID Prefix			Correction
Reg.#			Completed	Reg.#				Completed	Reg.#			Completed
LSC		=	LSC					LSC				
										-		
ID Prefix			Correction	ID Prefix				Correction	ID Prefix			Correction
ID FIEIIX			- Correction	ID FIEIX				Correction	ID FIEIIX			Correction
Reg. #		Completed	Reg. #				Completed	Reg.#			Completed	
LSC		_	LSC				LSC					
ID Prefix		Correction	ID Prefix				Correction ID Prefix				Correction	
Reg. #			Completed	Reg. #				Completed	Reg.#			Completed
LSC		- -	LSC				Completed	LSC			Completed	
LOU			_						LGC			
REVIEWED BY STATE AGENCY (INITIALS)				DATE SIGNATUI			RE OF SURVEYOR				DATE	
REVIEWE	D BY	REVIEWED BY		DATE TIT		TITLE	ITLE					

FOLLOWUP TO SURVEY COMPLETED ON

(INITIALS)

CMS RO

5/27/2021

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO