STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING _____________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345510

B. WING _____________________________

(X2) MULTIPLE CONSTRUCTION ______________________________________

(X3) DATE SURVEY COMPLETED 08/12/2020

NAME OF PROVIDER OR SUPPLIER

PRODIGY TRANSITIONAL REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

911 WESTERN BOULEVARD
TARBORO, NC 27886

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

E 000 Initial Comments

An unannounced COVID-19 Focused Survey was conducted on 8/12/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# OCPI11

F 000 INITIAL COMMENTS

An unannounced COVID-19 Focused Infection Control Survey was conducted on 8/12/2020. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event #OCPI11

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

E 000

F 000

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.