

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 535024	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 10/19/2016
NAME OF FACILITY POPLAR LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4305 S POPLAR CASPER, WY 82601	

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # NFPA 101	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC K0029	10/19/2016	LSC _____	_____	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 _____
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 _____	_____	LSC _____	_____
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # _____	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC _____	_____	LSC _____	_____	LSC _____	_____

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>TS</i>	DATE <i>11/2/16</i>	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE <i>11-1-16</i>
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/29/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO