

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 535024	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 1/31/2017	Y3
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 F0157	Correction	ID Prefix F0225	Correction	ID Prefix F0257	Correction
Reg. # 483.10(g)(14)	Completed	Reg. # 483.12(a)(3)(4)(c)(1)-(4)	Completed	Reg. # 483.10(i)(6)	Completed
LSC	01/24/2017	LSC	01/24/2017	LSC	01/24/2017
ID Prefix F0309	Correction	ID Prefix F0371	Correction	ID Prefix F0465	Correction
Reg. # 483.24, 483.25(k)(l)	Completed	Reg. # 483.60(i)(1)-(3)	Completed	Reg. # 483.90(h)(5)	Completed
LSC	01/24/2017	LSC	01/24/2017	LSC	01/24/2017
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>10/2/17</i>	DATE <i>2/1/18</i>	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			