

# INDEPENDENT HEALTH FACILITIES – POST-ASSESSMENT PLAN OF ACTION

**Facility Name & IHF #:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date Completed by Assessors:** | | | | **Assessor(s) Use only:** | |
| **A. REQUIREMENT FROM ASSESSMENT REPORT**  **(LISTED IN ORDER AS THEY APPEAR IN FINAL RECOMMENDATION SECTION)** | **B. POST ASSESSMENT ACTION PLAN & CORRECTIVE ACTION**  **(WHAT ACTION IS BEING TAKEN)** | **C. ACTION TAKEN BY & DATE MET**  **(WHO IS RESPONSIBLE or WHO IS MONITORING)** | **D. DOCUMENTATION PROVIDED TO CPSO**  **(PLEASE ATTACH AND IDENTIFY BY REQUIREMENT #)** | **IHF Response satisfies outstanding requirement**  **Yes/No** | **If NO, indicate and describe concern** |
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| This post assessment action plan was approved and signed off by: | |
| Name: | Name: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Licensee Signature and date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Quality Advisor Signature and date |
| Assessor(s) Signature & Date: | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessor Signature and Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assessor Signature and Date |