

# INDEPENDENT HEALTH FACILITIES – POST-ASSESSMENT PLAN OF ACTION

**Facility Name & IHF #:**

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| **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 |