

<b>Audit Review Period:</b>	
<b>Issue of non-compliance:</b>	Wound care
<b>Scope:</b>	<ul style="list-style-type: none"> <li>• The scope of this Impact Analysis is limited to 50% of the participants enrolled during the audit review period who were not included in the provision of services sample selection.</li> <li>• The auditor will select the participants to be reviewed and enter their identifying information on the Participant Impact tab.</li> </ul>
<b>Instructions:</b>	<ul style="list-style-type: none"> <li>• Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab.</li> <li>• Review the selected medical records to determine if the participants had wounds that required wound care.</li> <li>• Respond to the questions in the participant impact tab.</li> <li>• The review timeframe is the audit review period. Errors noted before or after the audit review period should not be included.</li> <li>• After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the changes in the RCA tab.</li> </ul>
<b>Impact Analysis Due Date:</b>	

<b>Date Identified (MM/DD/YY) (Completed By The CMS Audit Lead)</b>	<b>Brief Description Of Issue (Completed By The CMS Audit Lead)</b>	<b>Condition Language (Completed By The CMS Audit Lead)</b>

Detailed Description of the Issue	Root Cause Analysis for the Issue (Explain why it happened)	Methodology - Describe the process that was undertaken to determine the # of individuals (e.g. participants) impacted	# of Individuals Impacted	Action Taken to Resolve System/Operational Issues
<p>(Explain what happened) (Remaining fields to be Completed by PACE Organization)</p>				

Date System/ Operational Remediation Initiated (MM/DD/YY)	Date System/ Operational Remediation Completed (MM/DD/YY)	Actions Taken to Resolve Negatively Impacted Individuals Including Outreach Description and Status	Date Individual Outreach and Remediation Initiated (MM/DD/YY)	Date Individual Outreach and Remediation Completed (MM/DD/YY)

Participant First Name	Participant Last Name	Participant ID	Date of Enrollment	Date of Disenrollment
			MM/DD/YYYY	MM/DD/YYYY

<p>During the audit review period, did the participant have a wound (pressure, arterial, surgical, etc.) requiring wound care?</p> <p>(Yes/No)</p> <p>If No, the PO may enter NA in all remaining fields.</p>	<p>Enter the type of wound.</p> <p>If the participant had multiple wounds, list each wound in a new row.</p>	<p>Enter the date the wound was first noticed/documented.</p> <p>MM/DD/YYYY</p>	<p>If the wound was a pressure ulcer, enter the initial stage.</p> <p>Enter NA if the wound was not a pressure ulcer.</p>
---	--	---	---

<b>Was a wound care order required?</b> (Yes/No)	<b>Was wound care ordered by a PCP?</b> (Yes/No)	<b>When was wound care ordered?</b> MM/DD/YYYY Enter NA if wound care was not ordered.	<b>Enter the wound care order, if applicable.</b> Enter NA if wound care was not ordered.
---	---	--	--

<b>Was wound care provided without an order?</b>  (Yes/No)	<b>How frequently was wound care to be completed?</b>  Enter NA if wound care was not completed.	<b>Is there documentation that wound care was provided as frequently as required?</b>  (Yes/No)	<b>When <u>should</u> have wound care begun/been initiated?</b>  MM/DD/YYYY
--	--	---	---



<b>When did wound care begin (when was wound care initiated)?</b>  MM/DD/YYYY	<b>Is there documentation that wound care was provided as ordered?</b>  (Yes/No)	<b>If wound care was not provided as ordered, please describe how the wound care provided differed from the wound care ordered.</b>  Enter NA if wound care was provided as ordered.
---	--	--

<p>If the participant experienced negative outcomes, did they occur, in some part, as a result of the failure to provide the item or service?</p> <p>(Yes/No)</p>	<p>If yes, describe the negative outcomes.</p> <p>Enter NA if participant did not experience negative outcomes.</p>	<p>Optional: Please note, you do not have to complete this column.</p> <p>If there are any mitigating factors that you would like CMS to consider related to a specific participant, please enter the information in this column.</p>
---	---	---