Audit Review Period:	

Issue of non-compliance:	Wound care

Scope:	• The scope of this Impact Analysis is no more than 50% of the participants enrolled during the audit review period who were not included in the provision of services sample selection. • The auditor will select the participants to be reviewed and enter their identifying information on the Participant Impact tab.

Instructions:	• Review only the participant medical records selected by the auditor. The selected participants are identified in the Participant Impact tab. • Review the selected medical records to determine if the participants had wounds that required wound care. • Respond to the questions in the Participant Impact tab. • The review timeframe is the audit review period. Errors noted before or after the audit review period should not be included. • After completing the Impact Analysis, if any changes need to be made to the Root Cause Analysis, please update the RCA tab.

Impact Analysis Due Date:	

Brief Description Of Issue (Completed By The CMS Audit Lead)	Type of Issue Identified (Completed By The CMS Audit Lead) (Applies to condition 1P.02 Only. For all other conditions enter N/A)	Detailed Description of the Issue (Explain what happened)

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

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

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	Medicare Beneficiary Identifier	Participant ID	Date of Enrollment MM/DD/YYYY	Date of Disenrollment MM/DD/YYYY Enter NA if the participant is still enrolled.

Did the participant have a wound (pressure, arterial, surgical, etc.) that required wound care during the audit review period? (Yes/No) If <u>No</u>, enter NA in all remaining columns.	Was all wound care provided as ordered or authorized by the IDT during the audit review period? (Yes/No) If <u>Yes</u>, enter NA in all remaining columns.	What type of error occurred? • Wrong materials (dressing/medication) • Not completed as frequently as ordered • Completed more frequently than ordered • Wound care began before/after ordered start date (specify before or after) • Wound care ended before/after ordered end date (specify before or after) • Wound care was provided without a PACE PCP order • Necessary wound care was not provided because the PACE PCP failed to execute an order for wound care • Other error not specified You may enter more than one type of error, if applicable. Enter <u>each</u> wound care error in a <u>new row</u>. <u>Please note</u>: Impact analyses will be <u>returned</u> for correction if each medication error is not listed in a new row.

Identify the location and type of the wound. For example: left heel, stage II pressure ulcer	Enter the date the wound was first identified/documented. MM/DD/YYYY If the participant had multiple wounds, list each wound in a new row.	Date wound care was ordered by the PCP. MM/DD/YYYY If an order was required but wound care was not ordered, enter "Not Ordered." If a wound care order was not required, enter "Not Required." Only enter "Not Required," if an order is not required in accordance with all applicable state laws.	Enter the number of times the error occurred.

Did the wound heal? (Yes/No)	At any point, did the wound become infected? (Yes/No)	In what setting was or should the wound care have been provided? (PACE Center, SNF, ALF, Home)	Did a wound care error occur as a result of a failure to effectively coordinate care with a sub-acute facility such as a skilled nursing facility, nursing facility, assisted living facility, board and care facility, etc.? (Yes/No)

If the participant experienced negative outcomes, did they occur, in some part, as a result of a failure to order wound care, a failure to provide wound care as ordered by a PCP, because wound care was provided without an order, or a failure to communicate with a contracted provider? (Yes/No)	If yes, describe the negative outcomes. Enter NA if participant did not experience negative outcomes.	Optional: Please note, you do not have to complete this column. 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.