Audit Review Period:	

Issue of non-compliance:	Wound care

Scope:	• 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. • 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)	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.

During the audit review period, did the participant have a wound (pressure, arterial, surgical, etc.) requiring wound care? (Yes/No) If No, enter NA in columns G through X.	Enter the date the wound was first identified/documented. If the participant had multiple wounds, list each wound in a new row.	Enter the type of wound.	If the wound was a pressure ulcer, enter the initial stage. Enter NA if the wound was not a pressure ulcer.

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."**	**Enter the wound care order, if applicable.** **At a minimum, identify the the dressings/medications ordered and the frequency of wound care ordered.** **Enter NA if wound care was not ordered.**	**Does the medical record contain documentation that wound care was provided as ordered by the PCP?** **(Yes/No)** **Enter NA if wound care was not ordered.**

If wound care was not provided in accordance with the PCP orders, identify what occured: • No wound care provided • Incorrect frequency • Incorrect dressing/medication • Incorrect frequency and incorrect dressing/medication If another scenario applies, please describe how the wound care provided differed from the wound care ordered. Enter NA if wound care was not ordered.	Was wound care provided without an order? (Yes/No)	If wound care was provided without an order, enter the type of treatment provided. At a minimum, identify the dressings/medications used and the frequency of wound care provided. Enter NA if wound care was ordered or if wound care was not provided.

When <u>should</u> wound care have begun/been initiated? MM/DD/YYYY	When <u>did</u> wound care begin (when was wound care initiated)? MM/DD/YYYY	Did the wound heal? (Yes/No)	At any point, did the wound become infected? (Yes/No)

Did a failure to provide wound care occur due to ineffective communication with or oversight of a contracted provider? (Yes/No)	If the participant experienced negative outcomes, did they occur, in some part, as a result of the failure to provide the item or service? (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.