

Audit Review Period:	
Issue of non-compliance:	Wound care
Scope:	<ul style="list-style-type: none"> • 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:	<ul style="list-style-type: none"> • 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:	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1327. This information collection will allow CMS to conduct comprehensive reviews of PACE organizations to ensure compliance with regulatory requirements. The time required to complete this information collection is estimated at 780 per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory per CMS's authority under Section 1894 and 1934 of the Social Security Act and implementing regulations at 42 CFR § 460.190 and 460.194, which state that CMS, in conjunction with the State Administering Agency (SAA), audit PACE organizations (POs) annually for the first 3 contract years (during the trial period), and then on an ongoing basis following the trial period. Additionally, per § 460.200(a) PACE organizations are required to collect data, maintain records, and submit reports as required by CMS and the State administering agency. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Tracking ID Number	Brief Description Of Issue (Completed By The CMS Audit Lead)	Type of Issue Identified (Completed By The CMS Audit Lead) (Applies to condition <u>1P.02 Only</u> . For all other conditions enter N/A)	Detailed Description of the Issue (Explain what happened)
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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)
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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
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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)
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Participant First Name	Participant Last Name	Medicare Beneficiary Identifier	Participant ID	Date of Enrollment	Date of Disenrollment
				MM/DD/YYYY	MM/DD/YYYY
					Enter NA if the participant is still enrolled.

<p>Did the participant have a wound (pressure, arterial, surgical, etc.) that required wound care during the audit review period?</p>	<p>Was all wound care provided as ordered or authorized by the IDT during the audit review period?</p>	<p>What type of error occurred?</p>
<p>(Yes/No)</p>	<p>(Yes/No)</p>	<ul style="list-style-type: none"> • 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
<p>If <u>No</u>, enter NA in all remaining columns.</p>	<p>If <u>Yes</u>, enter NA in all remaining columns.</p>	<p>You may enter more than one type of error, if applicable.</p> <p>Enter <u>each</u> wound care error in a <u>new row</u>.</p> <p><u>Please note</u>: Impact analyses will be <u>returned</u> for correction if each wound care error is not listed in a new row.</p>

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	Date wound care was ordered by the PCP. MM/DD/YYYY	Enter the number of times the error occurred.
	If the participant had multiple wounds, list each wound in a new row.	<p>If an order was required but wound care was not ordered, enter "Not Ordered."</p> <p>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.</p>	

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?	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.
(Yes/No)		