| 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) | Detailed Description of the Issue (Explain what happened) (Remaining fields to be Completed by PACE Organization) | 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) |
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| Participant First Name | Participant Last Name | Participant ID | If Hospitalized, Most Recent Date of Hospitalization. [MM/DD/YY] | If Participant Went to the Emergency Room, Most Recent Date of Emergency Room Visit. [MM/DD/YY] | Was This the Initial Plan of Care, Semi-annual Revision to the Plan of Care, Annual Revision to the Plan of Care, or Unscheduled Revision to the Plan of Care? | If Applicable, Date of the Previous Plan of Care Revision [MM/DD/YY] | Did the Plan of Care Require a Revision? [Y/N] | Date the Plan of Care Was or Should Have Been Completed or Revised by the IDT. [MM/DD/YY] | IDT Members (Disciplines) Actively Involved in the Development and Implementation of the Participant's Plan of Care at the Time of the Assessment. | IDT Members (Disciplines) Who Completed an Assessment. | Date the IDT Members (Disciplines) Completed the Assessments. (Identify Assessment Date by Discipline) [MM/DD/YY] | Was There a Change in the Participant's Status? [Y/N] | If Yes, Describe the Change in the Participant's Status. | Remote Assessments Were Delayed or Not Completed. | Did the Plan of Care Specify the Care Needed to Meet the Participant's Medical, Physical, Emotional and Social Needs? [Y/N] | Did the Plan of Care Identify Measurable Outcomes to Be Achieved? [Y/N] | Did the IDT Develop, Review and Reevaluate the Plan of Care in Consultation with the Participant or Caregiver, or Both, to Ensure That There Is Agreement With the Plan of Care and That the Participant's Concerns Were Addressed? | Were There Any Negative Participant Outcomes? [Y/N] | If Yes, Describe the Negative Outcomes | [Other Data Requested] | [Other Data Requested] | [Other Data Requested] |
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