MDS ALIGNMENT REPORT

Professional Session Analysis

Generated: 12/29/2025

Session ID:	21C9BCF	**Risk Level:**	HIGH
Processed Date:	12/29/2025	**Alignment Score:**	0%

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1. EXECUTIVE SUMMARY

Expected actions include care coordinators reviewing highlighted documentation inconsistencies, seeking clarification, and ensuring consistent support for skilled needs.

2. KEY OBSERVATIONS

- **Session Type:** Documentation Analysis Report
- **Presenting Concerns:** Identified documentation inconsistencies, potential payment risk, and increased exposure to survey deficiencies.
- **Interventions Used:** Analysis of resident documentation for alignment and identification of gaps. Provision of risk flags and supportive guidance for review.
- **Response:** Expected actions include care coordinators reviewing highlighted documentation inconsistencies, seeking clarification, and ensuring consistent support for skilled needs.
- **Progress Toward Goals:** The report provides a framework to reduce survey risk, protect payment, improve assessment accuracy, and enable quick identification of documentation gaps.
- **Clinical Impression:** No clinical impressions are provided, as the report focuses exclusively on documentation quality and alignment, not resident health or treatment.
- **Safety Concerns:** Documentation inconsistencies pose risks to compliance, accurate reimbursement, and potential adverse outcomes during facility surveys.
- **Follow-up Recommendations:** Ongoing review of documentation consistency across disciplines, clarification of unclear entries, and ensuring consistent support for skilled services.

3. RISK ANALYSIS

Total Risk Flags Detected: 3

RISK FLAG 1 - Activities of Daily Living (ADL) (HIGH)

Description: Contradictions observed between nursing notes and therapy documentation regarding a resident's ADL performance.

Why it matters: Inconsistent ADL documentation can lead to inaccurate assessment coding, impacting payment levels and increasing vulnerability during compliance surveys.

Evidence: Discrepancies noted in ADL functional status entries by different care providers.

Severity: HIGH

RISK FLAG 2 - Therapy (MEDIUM)

Description: Skilled need for therapy services is not consistently supported across all documentation, particularly between therapy notes and nursing progress notes.

Why it matters: Lack of consistent support for skilled services can jeopardize reimbursement for therapy and lead to denials during audits, indicating potential non-compliance.

Evidence: Absence of consistent narrative linking therapy interventions to a skilled need in various documentation sources.

Severity: MEDIUM

RISK FLAG 3 - Diagnosis (LOW)

Description: Certain diagnoses are referenced in some areas of the record without sufficient supporting documentation or clear connection to current care needs.

Why it matters: Diagnoses lacking clear support can impact the accuracy of the assessment, potentially influencing payment case mix groups and leading to questions during surveys regarding medical necessity.

Evidence: Diagnoses noted in care plans or physician orders without corroborating details in progress notes or assessments.

Severity: LOW

4. PDPM ALIGNMENT

This report specifically analyzes resident documentation to ensure alignment with payment guidelines, identifying discrepancies that could impact payment accuracy.

Note: *Key areas of focus include consistency in ADL reporting, skilled need justification, and therapy minute documentation, all critical components influencing payment calculations and audit readiness.*

5. CONSISTENCY CHECKS

- **ADL Conflicts:** Identification of contradictory entries in ADL performance documentation between nursing and therapy records.
- **Behavior Conflicts:** Detection of inconsistent reporting or description of resident behaviors across different care provider notes.
- **Therapy Conflicts:** Analysis reveals mismatches between documented therapy minutes and the corresponding functional progress or skilled need justifications.
- **Pain Conflicts:** Inconsistencies observed in the assessment, reporting, or management of resident pain levels across various documentation sources.
- **Diagnosis Alignment:** Review highlights instances where diagnoses are referenced without consistent, supporting documentation or clear integration into the resident's plan of care.

6. DETAILED SCORES

Overall Alignment Score	0%
Documentation Quality	0%
Consistency Score	0%
Compliance Score	0%
Risk Assessment	high

Risk Distribution

High Risk	1 flags (33%)	
Medium Risk	1 flags (33%)	
Low Risk	1 flags (33%)	

7. RECOMMENDATIONS

1. Review all highlighted documentation inconsistencies
2. Clarify ambiguous or contradictory entries with relevant staff
3. Ensure consistent support for skilled needs across all documentation
4. Update care plans to reflect accurate assessment findings
5. Implement regular documentation quality audits
6. Provide staff training on MDS documentation requirements
7. Establish follow-up procedures for high-risk findings