

MDS-PDPM DOCUMENTATION VALIDATION

MDS-PDPM Documentation Validation: Resident R-2041

Birchwood Rehabilitation and Nursing (fictional) · 5-day PPS assessment · ARD 03/12/2026

FACILITY	Birchwood Rehabilitation and Nursing (fictional)
RESIDENT	R-2041, admitted 03/06/2026 from acute hospital after left hip fracture repair
ASSESSMENT	5-day PPS, assessment reference date (ARD) 03/12/2026; look-back 03/06 to 03/12/2026 unless the item states otherwise
SOURCES	Hospital discharge summary, admission nursing assessment, nursing notes, therapy evaluations, physician orders, dietary assessment, MAR, wound sheet. 214 pages. 6 duplicate pages removed.
PREPARED FOR	T. Halvorsen, RN, MDS coordinator
PREPARED BY	Medrecords AI draft, 10/08/2026, for coordinator review

AI does the reading. You review, you revise, you sign.

Medrecords AI demo case. Every name, provider, date and page in this document is fictional.

Overview

This validation takes each coded item on the 5-day assessment and finds the chart note that supports it. Where the note supports the coded value, the row says so and gives the page. Where support is partial, absent or where 2 notes disagree, the row carries a flag. The flags are signals. They do not say how an item should be coded; the coordinator decides that.

Flag key: Supported, the chart note matches the coded value. Partial, part of the coded value is documented. Not found, no note in the look-back supports the coded value. Conflict, 2 notes in the look-back disagree.

Section I: active diagnoses

MDS ITEM	CODED VALUE	SUPPORTING NOTE AND PAGE	FLAG
I0020B, primary medical condition (ICD-10)	S72.002D, fracture of unspecified part of neck of left femur, subsequent encounter	Hospital discharge summary lists "left femoral neck fracture, s/p hemiarthroplasty 03/03/2026"; admitting physician order sheet repeats it	SUPPORTED p. 4, p. 22
I0020, primary condition category	Orthopedic surgery, hip replacement	Operative note in hospital packet: "left hip hemiarthroplasty"	SUPPORTED p. 9
I2900, diabetes mellitus	Checked	Problem list and metformin order; fingerstick glucose on MAR	SUPPORTED p. 22, p. 31, p. 140
I4900, hemiplegia or hemiparesis	Checked	No note in the look-back documents hemiplegia or hemiparesis. Hospital history mentions "remote right-sided weakness after 2019 stroke, resolved"	NOT FOUND p. 5
I5100, quadriplegia	Not checked	n/a	SUPPORTED

MDS ITEM	CODED VALUE	SUPPORTING NOTE AND PAGE	FLAG
I6300, respiratory failure	Checked	No oxygen order, no ABG, no physician note in the look-back. Hospital summary mentions "brief post-op hypoxia, resolved on room air 03/04"	NOT FOUND p. 6
I8000, additional active diagnosis	N18.30, chronic kidney disease stage 3	Hospital summary problem list; eGFR 48 on 03/06 admission labs	SUPPORTED p. 5, p. 58
I8000, additional active diagnosis	E44.0, moderate protein-calorie malnutrition	Dietitian assessment 03/08 records "at risk, BMI 20.1, intake 50 to 75 percent"; no physician documentation of malnutrition in the look-back	PARTIAL p. 112

Section GG: functional abilities, admission performance

MDS ITEM	CODED VALUE	SUPPORTING NOTE AND PAGE	FLAG
GG0130A, eating	05, setup or clean-up assistance	Nursing admission assessment 03/06: "sets up tray, feeds self"; OT eval 03/07: "independent after setup"	SUPPORTED p. 70, p. 98
GG0130B, oral hygiene	04, supervision or touching assistance	OT eval 03/07: "supervision for safety at sink"; nursing 03/06: "setup only"	CONFLICT p. 98, p. 70
GG0130C, toileting hygiene	03, partial/moderate assistance	Nursing notes 03/06, 03/08, 03/10: "assist of 1 for peri-care"; OT eval 03/07: "mod A"	SUPPORTED p. 70, p. 74, p. 78, p. 98
GG0170B, sit to lying	03, partial/moderate assistance	PT eval 03/07: "mod A to supine, hip precautions"	SUPPORTED p. 104
GG0170C, lying to sitting on side of bed	03, partial/moderate assistance	PT eval 03/07: "mod A"	SUPPORTED p. 104
GG0170D, sit to stand	02, substantial/maximal assistance	PT eval 03/07: "max A x 1 with walker"; nursing 03/09: "assist x 2 to stand"	CONFLICT p. 104, p. 76
GG0170E, chair/bed-to-chair transfer	02, substantial/maximal assistance	PT eval 03/07: "max A"; nursing 03/06 through 03/12 record "assist x 2" on 4 of 7 days	CONFLICT p. 104, p. 70 to p. 82
GG0170I, walk 10 feet	02, substantial/maximal assistance	PT eval 03/07: "ambulated 8 feet with rolling walker, max A, seated due to fatigue"	PARTIAL p. 105
GG0170J, walk 50 feet with 2 turns	88, not attempted due to medical condition	PT eval 03/07 and PT note 03/10: 8 feet and 15 feet recorded; no 50-foot attempt documented	SUPPORTED p. 105, p. 108
GG0170R, wheel 50 feet with 2 turns	09, not applicable	PT eval: "wheelchair for transport only, propelled by staff"	SUPPORTED p. 105
GG0130A to GG0170S, discharge goals	Coded for all items	PT and OT evaluations state goals for eating, oral hygiene, toileting hygiene, sit to stand, transfers, walk 10 and 50 feet; no stated goal for sit to lying or lying to sitting	PARTIAL p. 99, p. 106

Sections K and O: nutrition, swallowing, special treatments

MDS ITEM	CODED VALUE	SUPPORTING NOTE AND PAGE	FLAG
K0100, swallowing disorder	Z, none of the above	Nursing admission screen: "no coughing with meals"; SLP screen 03/08: "no indicators"	SUPPORTED p. 71, p. 116

MDS ITEM	CODED VALUE	SUPPORTING NOTE AND PAGE	FLAG
K0200, height and weight	66 inches, 124 lb	Admission weight 03/06: 124 lb; height from hospital summary 66 inches; no facility-measured height in look-back	PARTIAL p. 70, p. 4
K0300, weight loss	1, loss of 5 percent or more in 30 days, not on prescribed weight-loss regimen	Hospital weight 02/28: 131 lb (p. 7); facility weight 03/06: 124 lb; dietitian note 03/08 calculates 5.3 percent	SUPPORTED p. 7, p. 70, p. 112
K0510A2, parenteral/IV feeding while a resident	Checked	IV fluids documented 03/06 to 03/07 on MAR, 75 mL per hour, "for hydration"; no IV nutrition order	CONFLICT p. 140, p. 24
K0510C2, mechanically altered diet	Checked	Diet order 03/06: "regular, chopped meats"; dietitian confirms	SUPPORTED p. 24, p. 112
O0100C2, oxygen therapy while a resident	Not checked	No oxygen order in the look-back; nursing 03/06 records "room air, SpO2 95 percent"	SUPPORTED p. 70
O0100H2, IV medications while a resident	Checked	MAR: cefazolin IV every 8 hours 03/06 to 03/08, 7 doses	SUPPORTED p. 141
O0100M2, isolation or quarantine	Not checked	No isolation order; infection control log blank for this resident	SUPPORTED p. 160
O0400A, speech-language pathology days and minutes	0 days	SLP screen only on 03/08; no treatment minutes documented	SUPPORTED p. 116

Sections C, D, M and N: cognition, mood, skin, medications

MDS ITEM	CODED VALUE	SUPPORTING NOTE AND PAGE	FLAG
C0500, BIMS summary score	13	BIMS form dated 03/11, signed by social services, total 13	SUPPORTED p. 122
D0300, PHQ-9 total severity score	6	PHQ-9 interview dated 03/11, total 6	SUPPORTED p. 124
J1100, shortness of breath	Z, none of the above	Nursing notes 03/06 to 03/12: no shortness of breath recorded; respiratory rate 16 to 20	SUPPORTED p. 70 to p. 82
M0300B1, stage 2 pressure ulcers, number present	1	Wound sheet 03/06: "sacrum, stage 2, 2.0 x 1.5 cm, present on admission"	SUPPORTED p. 150
M0300B2, number of stage 2 present on admission	1	Same wound sheet and hospital discharge summary skin section	SUPPORTED p. 150, p. 6
M1040F, surgical wound	Checked	Left hip incision, staples, documented 03/06 and 03/10	SUPPORTED p. 150, p. 152
N0415A1, antipsychotic	Not checked	No antipsychotic on MAR or order sheet in the look-back	SUPPORTED p. 140 to p. 146
N0415E1, anticoagulant	Checked	Enoxaparin 40 mg subcut daily, 03/06 to 03/12 on MAR	SUPPORTED p. 142
N0415H1, opioid	Checked	Oxycodone 5 mg PRN, 9 doses in look-back on MAR	SUPPORTED p. 144
N0415I1, antiplatelet	Checked	Aspirin 81 mg listed on hospital discharge medication list; no facility order and no MAR entry in the look-back	NOT FOUND p. 8, p. 140 to p. 146

Items where 2 notes disagree

ITEM	NOTE 1	NOTE 2	PAGES
GG0130B, oral hygiene	OT 03/07: supervision at sink	Nursing 03/06: setup only	p. 98, p. 70
GG0170D, sit to stand	PT 03/07: max assist of 1 with walker	Nursing 03/09: assist of 2 to stand	p. 104, p. 76
GG0170E, transfers	PT 03/07: max assist of 1	Nursing, 4 of 7 days: assist of 2	p. 104, p. 70 to p. 82
K0510A2, IV feeding	MDS coded IV feeding	MAR and order: IV fluids for hydration, no nutrition order	p. 140, p. 24

Pages the validation expected and did not find

- A physician note in the look-back documenting hemiparesis (I4900) or respiratory failure (I6300). The only mentions are in the hospital history and describe resolved conditions (p. 5, p. 6).
- A facility order for aspirin (N0415I1). It appears on the hospital discharge list only (p. 8).
- A facility-measured height (K0200). Height is carried from the hospital summary (p. 4).
- A physician or nurse practitioner note addressing the dietitian's malnutrition risk entry (I8000, E44.0).
- Nursing documentation of a 10-foot walk; the only distance records are in therapy notes (p. 105, p. 108).

No coding advice appears in this document. Each flag marks a place where the chart and the coded item do not line up, for the coordinator to resolve. Medrecords AI organizes, cites and flags what is in the uploaded files. You review, you revise, you sign.