SKILLED NURSING DOCUMENTATION NAVIGATOR

USE DURING: Skilled nursing visits | IDG updates | Face-to-face support | Recertification review | CTI support

Build every note around a clear clinical story

1 ASSESS What did I assess?	2 CHANGE What changed?	3 ACT What did I do?	4 RESPONSE How did the patient respond?	5 MEANING Why does it matter?
THINK	**LOOK FOR**		**DOCUMENT**	
Cognition	FAST stage, communication, commands		Specific current ability and change from prior status	
Mobility	Ambulation, transfers, bed/chair status		Assistance required, falls and safety risk	
ADLs	Bathing, dressing, toileting, feeding		Number and type of ADLs requiring help	
Swallowing	Coughing, choking, pocketing		Aspiration risk, diet change and teaching	
Nutrition	Bites/sips, meal percentage, weight		Reduced intake and hydration indicators	
Complications	Infection, fever, pressure injuries		Episode, treatment and impact on decline	
Caregiver	Supervision and total care needs		New or increasing caregiver burden	

CANCER

DISEASE BURDEN + SYMPTOM RESPONSE

OBSERVE	COMPARE	CONNECT
Specific current findings	Change from prior status	Why the finding supports decline

THINK	LOOK FOR	DOCUMENT
Progression	Metastatic/progressive disease	Current progression and treatment status
Function	PPS, bed/chair time, tolerance	Change in function and activity

SAMPLE DOCUMENTATION

Patient with metastatic lung cancer has declined from PPS 50% to 40% and now spends most of the day in bed or a recliner. Intake is limited to several bites per meal, and mid-arm circumference decreased from 24 cm to 22.5 cm this benefit period. Patient reports increasing right chest pain requiring three breakthrough morphine doses in the past 24 hours. Skilled nursing reviewed dosing, administered the ordered breakthrough medication, and reassessed pain from 7/10 to 3/10 within 40 minutes.

SAMPLE DOCUMENTATION

Patient demonstrates increasing abdominal distention, early satiety and weakness related to progressive ovarian cancer. Patient now requires assistance with bathing, dressing and transfers and can walk only a few steps with support. Nausea has increased despite scheduled medication, with two episodes of vomiting since yesterday. Skilled nursing assessed hydration and bowel status, reinforced small frequent sips, and contacted the hospice provider for symptom-management orders.

CARDIOPULMONARY DISEASE

HEART + PULMONARY

OBSERVE	COMPARE	CONNECT
Specific current findings	Change from prior status	Why the finding supports decline

THINK	LOOK FOR	DOCUMENT
Symptoms at rest	Dyspnea, chest discomfort, fatigue	Severity, frequency and baseline comparison
Minimal activity	Talking, eating, transfer, toileting	Trigger and recovery time

SAMPLE DOCUMENTATION

Patient becomes short of breath while speaking and requires approximately five minutes to recover after transferring from bed to chair. Oxygen use has increased from 2 L/min at night to 3 L/min continuously. Respirations are 26/min with accessory muscle use and diminished breath sounds bilaterally. Skilled nursing positioned patient upright, reinforced pursed-lip breathing and administered ordered medication. Respiratory effort decreased and patient was able to speak in short sentences after 20 minutes.

SAMPLE DOCUMENTATION

Patient with advanced heart failure has increased bilateral lower-extremity edema from 2+ to 3+, a 4-pound weight gain in one week and new dyspnea at rest. Patient now requires assistance to toilet because of fatigue and breathlessness. Skilled nursing assessed lung sounds and medication use, reinforced sodium and fluid guidance in the plan of care, and notified the hospice provider of the change in symptoms and fluid burden.

NEUROLOGIC CONDITIONS

ALS, STROKE, PARKINSON'S, COMA + OTHER DECLINE

OBSERVE	COMPARE	CONNECT
Specific current findings	Change from prior status	Why the finding supports decline

THINK	LOOK FOR	DOCUMENT
Mobility	Ambulation, transfers, trunk control	Progressive loss and assistance level
Swallowing	Dysphagia, choking, aspiration	Diet, intake and safety intervention

SAMPLE DOCUMENTATION

Patient with ALS has worsening upper-extremity weakness and can no longer bring utensils to the mouth independently. Speech is faint and difficult to understand, and patient requires frequent pauses while eating because of fatigue. Caregiver reports two choking episodes this week. Skilled nursing assessed swallowing and respiratory status, reinforced texture modification and upright positioning, and notified the hospice provider and IDG of increased aspiration risk.

SAMPLE DOCUMENTATION

Since the last recertification, patient with Parkinson's disease has progressed from one-person to two-person assistance for transfers and is no longer able to ambulate safely. Patient has increased rigidity, a weak cough and greater difficulty clearing oral secretions. Skilled nursing reviewed transfer safety and secretion management with the caregiver and coordinated equipment needs with the interdisciplinary team.

RENAL AND LIVER DISEASE

TREATMENT CHOICES + SYSTEMIC DECLINE

OBSERVE	COMPARE	CONNECT
Specific current findings	Change from prior status	Why the finding supports decline
THINK	**LOOK FOR**	**DOCUMENT**
Treatment choice	Dialysis/transplant decisions	Current plan and comfort focus
Symptoms	Fatigue, nausea, itching, confusion	Severity, change and intervention

SAMPLE DOCUMENTATION

Patient with end-stage renal disease who has elected no further dialysis demonstrates increasing fatigue, confusion and generalized edema. Urine output has decreased to approximately 200 mL in 24 hours, and patient now requires total assistance with bathing, dressing and transfers. Skilled nursing assessed fluid burden, respiratory status and safety, reviewed expected changes with the caregiver, and reinforced when to call hospice for worsening dyspnea or agitation.

SAMPLE DOCUMENTATION

Patient with advanced liver disease has worsening ascites, jaundice and intermittent confusion. Abdominal girth increased by 4 cm since last week, intake is limited to sips and several bites daily, and patient requires assistance with all ADLs. Skilled nursing assessed abdominal discomfort, bleeding risk and mental-status changes, provided skin and safety teaching, and contacted the hospice provider regarding increased symptom burden.

FRAILTY AND COMPLEX DECLINE

SUPPORTING EVIDENCE, NOT THE ONLY STORY

OBSERVE	COMPARE	CONNECT
Specific current findings	Change from prior status	Why the finding supports decline

THINK	LOOK FOR	DOCUMENT
Disease story	Primary condition driving prognosis	Connect frailty findings to disease process
Function	PPS/Karnofsky, bed/chair, ADLs	Current level and measurable change

SAMPLE DOCUMENTATION 1

Patient with advanced heart disease and recurrent infections has declined from PPS 50% to 40%. Patient now requires assistance with five of six ADLs, spends approximately 20 hours daily in bed or a chair, and eats less than 25% of meals. Caregiver reports two falls and increasing nighttime supervision needs. Skilled nursing assessed orthostatic symptoms, transfer safety and hydration, reinforced fall precautions, and updated the IDG regarding increased care needs.

SAMPLE DOCUMENTATION 2

Patient with complex decline related to COPD, chronic kidney disease and severe frailty has lost 8 pounds during this benefit period and has visible temporal and clavicular wasting. Patient becomes exhausted during personal care and now requires two-person assistance for transfers. A new skin tear and worsening incontinence increase the risk for additional skin breakdown. Skilled nursing completed skin care, reviewed pressure-injury prevention and coordinated additional caregiver support.

BEFORE YOU SIGN: 30-SECOND NOTE CHECK

A fast final review before closing the skilled nursing note

QUICK CHECK	YES / NO
Did I document what I observed, not just what I did?	☐ YES ☐ NO
Did I describe change since the last visit, week or benefit period?	☐ YES ☐ NO
Did I include function, nutrition, symptoms, complications or caregiver impact when relevant?	☐ YES ☐ NO

FINAL REMINDER

The CTI narrative is supported by the details within the clinical record. Clinicians are encouraged to document specific findings, meaningful changes, symptom burden, complications, care needs, caregiver impact and response to interventions throughout the benefit period. This reference tool is intended to support staff education and documentation practices. It does not replace clinical judgment, agency policy, physician orders, CMS regulations, LCD requirements, or MAC guidance. Documentation must reflect the individual patient's condition and the medical record.