AI Documentation for Skilled Nursing Facilities Explained

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Executive Summary

Skilled nursing facilities (SNFs) in the United States face a documentation burden that is well documented in the clinical literature and increasingly addressed by artificial intelligence. Nurses working in EHR-based systems have been shown to document between 600 and 800 discrete data points per 12-hour shift, or roughly one entry every 1.11 minutes (Source: pmc.ncbi.nlm.nih.gov), and the U.S. Surgeon General's Advisory on health worker burnout found that nurses spend, on average, about 40 percent of a shift on documentation (Source: aacn.org). Nurses are also the largest group of EHR end users in healthcare (Source: pmc.ncbi.nlm.nih.gov), and the national bedside-nurse turnover rate rose from 16.8 percent in 2019 to 18.7 percent in 2021 (Source: pmc.ncbi.nlm.nih.gov). Against that backdrop, "AI documentation" in the skilled nursing setting has emerged as a distinct software category spanning at least four overlapping types of tools: ambient AI scribes that transcribe and structure encounter notes in real time, AI-assisted Minimum Data Set (MDS) and Patient-Driven Payment Model (PDPM) coding assistants, clinical documentation improvement (CDI) tools that flag missing or inconsistent evidence, and AI features embedded directly inside electronic health record (EHR) platforms such as PointClickCare and MatrixCare.

The regulatory stakes are unusually high in this setting. The MDS 3.0 Resident Assessment Instrument, whose current version (v1.20.1) took effect October 1, 2025, is a mandatory, federally standardized assessment for every Medicare- or Medicaid-certified nursing home resident (Source: cms.gov) (Source: aapacn.org), and MDS coding errors flow directly into PDPM reimbursement, the Five-Star Quality Rating System, and Medicare audit exposure (Source: cms.gov). A 2025 Office of Inspector General audit found that one nursing and rehabilitation center failed Medicare documentation and coding requirements on 99 of 100 sampled claims, producing an estimated overpayment of at least $31.2 million (Source: oig.hhs.gov), and since 2023 the Centers for Medicare & Medicaid Services (CMS) has run targeted audits of schizophrenia coding on the MDS that can downgrade or suppress a facility's Five-Star rating (Source: cms.gov) (Source: leadingage.org).

Vendors report substantial efficiency gains. DevXT's NurseXT claims a 75 percent reduction in charting time (Source: devxt.com); Nanonets Health reports a 60 percent reduction in MDS preparation time (Source: nanonets.health); and DolphinCare reports $2,400 to $6,250 in incremental monthly revenue per facility across its user base (Source: dolphincare.ai). Independent peer-reviewed evidence is more cautious: a 2025 systematic review of AI scribes across all clinical settings found the evidence base "limited and heterogeneous" (Source: pmc.ncbi.nlm.nih.gov), and a 2025 instrument-validation study in the Journal of Medical Internet Research found 127 documentation errors across 44 ambient-scribe draft notes, with 70 percent of notes containing at least one error (Source: jmir.org).

The market context is one of rapid but fragmented growth. The U.S. long-term care software market was estimated at $2.41 billion in 2025 and is projected to reach $4.11 billion by 2033, a compound annual growth rate of 6.92 percent (Source: grandviewresearch.com), while the nursing home sector added 40,700 jobs in 2025 even as 90 percent of providers still report recruitment difficulty (Source: ahcancal.org) (Source: ahcancal.org). This report defines the category, walks through each major tool type, quantifies the evidence for and against AI documentation adoption, and profiles five real-world deployments and regulatory actions, from a peer-reviewed 94-facility MatrixCare study to the CMS schizophrenia-coding audits. Throughout, the analysis distinguishes vendor-reported outcomes from independently measured ones and treats life-sciences advisory perspectives, such as those published by consultancies like intuitionlabs.ai, as a complementary lens on governance rather than as a competing software option (Source: intuitionlabs.ai).

Introduction and Background

Skilled nursing facilities operate under one of the most document-intensive regulatory regimes in American healthcare. Every Medicare- or Medicaid-certified nursing home resident must be assessed using the Minimum Data Set (MDS), described by the American Association of Post-Acute Care Nursing (AAPACN) as "a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid" (Source: aapacn.org). The MDS sits inside the broader Resident Assessment Instrument (RAI), which AAPACN describes as helping "nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan" (Source: aapacn.org). The current MDS 3.0 RAI User's Manual, version 1.20.1, took effect October 1, 2025, and CMS updates it on a rolling basis, including a June 2026 revision to the list of State RAI Coordinators and MDS Automation Coordinators, as coding guidance and item sets change (Source: cms.gov).

Since October 1, 2019, MDS data has also driven reimbursement directly through the Patient-Driven Payment Model (PDPM), the case-mix classification system CMS finalized in July 2018 to replace the therapy-minutes-based RUG-IV model for Medicare Part A-covered SNF stays (Source: cms.gov). CMS states plainly that PDPM, "effective October 1, 2019, will improve payments made under the SNF PPS" relative to the prior model (Source: cms.gov), and the transition was abrupt rather than phased: RUG-IV billing ended September 30, 2019, and PDPM billing began the very next day, October 1, 2019 (Source: cms.gov).

CMS itself has acknowledged that this assessment burden is a policy problem, not merely an operational inconvenience. In building the case for PDPM, the agency projected that "the simplified patient assessments will significantly reduce reporting burden, saving an estimated $2 billion over 10 years" (Source: cms.gov) as part of the broader Patients over Paperwork initiative, which CMS estimated in January 2019 would save the healthcare system 40 million hours and $5.7 billion through 2021 across all regulatory reforms (Source: cms.gov). By the time of that 2019 request for public input, CMS reported it had already addressed or was in the process of addressing 83 percent of the actionable burden areas identified through an earlier 2017 request for information (Source: cms.gov), and a related "Meaningful Measures" initiative eliminated 79 overly burdensome or low-value quality measures for a projected $128 million in savings and 3.3 million fewer burden hours through 2020 (Source: cms.gov). Independent academic research on a related CMS effort, the Evaluation & Management coding simplification, found that documentation word counts in outpatient visit notes fell in each year following the Patients over Paperwork rollout, with 2021 associated with the greatest reduction across every quantile studied, evidence that policy-level burden reduction can measurably change clinician behavior over time even before AI tools enter the picture (Source: pmc.ncbi.nlm.nih.gov) (Source: pmc.ncbi.nlm.nih.gov). The same research literature notes that primary care physicians generally spend an additional two hours on EHR and administrative work for every hour of direct patient care they deliver, a ratio widely cited as a driver of burnout (Source: pmc.ncbi.nlm.nih.gov).

Software vendors have moved into this gap with generative and predictive AI tools aimed specifically at post-acute care. This activity intersects with a demographic and workforce context that makes automation attractive on both sides of the ledger. On the demand side, the U.S. population aged 65 and older grew 3.1 percent between 2023 and 2024 to reach 61.2 million people (Source: grandviewresearch.com), the population aged 65 and older nationally is projected to reach 94.7 million by 2060 (Source: pmc.ncbi.nlm.nih.gov), and the average nursing home resident is 79 years old (Source: ahcancal.org), with the population 80 and older expected to grow by 8 million over the next decade (Source: ahcancal.org). On the supply side, the nursing home sector gained 40,700 jobs in 2025 (Source: ahcancal.org), yet the sector's overall employment remains 1.7 percent below pre-pandemic levels and 90 percent of providers still describe recruitment as difficult (Source: ahcancal.org) (Source: ahcancal.org). A national projection cited by

Grand View Research anticipates a shortage of 78,610 full-time registered nurses in 2025 alone, easing only slightly to 63,720 by 2030 (Source: grandviewresearch.com). This report examines what AI documentation tools actually do in a skilled nursing context, how they intersect with MDS, PDPM, and CDI workflows, what independent evidence says about their accuracy and impact, and how operators can evaluate and govern them responsibly.

What "AI Documentation" Means in a Skilled Nursing Facility

"AI documentation" is not a single product category; it is an umbrella term covering at least four distinct types of software that overlap in practice but differ in function, risk profile, and buyer. Distinguishing them matters because the compliance considerations, and the evidence supporting each, differ substantially. Documentation burden itself is formally defined in the nursing literature as "the increased effort and time demand to document patient care in the EHR," a construct that includes EHR workload and usage, clinical documentation and review, and cognitively cumbersome work (Source: pmc.ncbi.nlm.nih.gov), and researchers note that federal policies such as the HITECH Act of 2009 helped drive that burden upward by implementing electronic clinical quality measures intended to track EHR viability (Source: pmc.ncbi.nlm.nih.gov).

Ambient AI scribes listen to or transcribe a clinical encounter, whether a nurse practitioner's admission visit, a physician's rounding note, or a therapy session, and generate a structured draft note. Vendors marketing into skilled nursing specifically include Twofold Health, DevXT's NurseXT, and Lime Health AI, among others identified in this research. These tools descend from a longer lineage of human medical scribes, which the peer-reviewed literature describes as professionals "who specialize in the real-time documentation of patient-physician interactions," employed originally to reduce administrative burden but limited by "high cost, training requirements, and high turnover rates" that made them unsustainable at scale in many settings (Source: pmc.ncbi.nlm.nih.gov) (Source: pmc.ncbi.nlm.nih.gov).

MDS and PDPM coding assistants ingest hospital discharge summaries, physician orders, and daily clinical notes, then surface or auto-suggest the codes an MDS coordinator should select for a given assessment item, along with a citation back to the supporting chart evidence. DolphinCare, Anthuria, Nanonets Health, and the PDPM Coach module built into the PointClickCare EHR fall into this category. Anthuria describes its core value proposition as helping MDS staff find "clinical evidence you need [that is] buried across hundreds of pages of hospital paperwork, physician orders, and daily notes," with every suggestion linked "directly to the source documentation" (Source: anthuria.ai), and Lime Health AI similarly structures observations "into the categories MDS coordinators care about: ADLs, cognitive status, mood, skin, falls, restraints, and Section GG functional items" (Source: getlimeai.com).

Clinical documentation improvement (CDI) and compliance-monitoring tools sit adjacent to coding assistants but focus on auditing documentation quality after the fact, flagging missing physician certifications, inconsistent diagnosis coding, or gaps that would fail an Additional Documentation Request (ADR) from a Medicare Administrative Contractor. Industry analyst firm KLAS tracks CDI as a distinct software category within revenue cycle technology, separate from ambient AI and computer-assisted coding (Source: klasresearch.com).

EHR-embedded AI and analytics are features built directly into a facility's core clinical system rather than sold as standalone add-ons. PointClickCare's **Chart Advisor** performs AI-powered risk management and its **CareComply** module performs AI-powered compliance monitoring, both native to the core PointClickCare platform and part of a broader ecosystem of more than 400 marketplace integration partners (Source: intuitionlabs.ai) (Source: intuitionlabs.ai), while MatrixCare's Clinical Advanced Insights (CAI) functionality, introduced in 2021, applies machine learning to flag early risk signals for falls, depression, and respiratory decline (Source: skillednursingnews.com).

Table 1 below summarizes these four categories, their typical function, and representative products identified in this research.

CATEGORY	PRIMARY FUNCTION	TYPICAL BUYER	REPRESENTATIVE PRODUCTS
Ambient AI scribes	Transcribe and structure encounter notes in real time from spoken conversation	Physicians, NPs, PAs, nursing staff	Twofold Health, DevXT NurseXT, Lime Health AI
MDS/PDPM coding assistants	Surface or auto-suggest MDS item codes and PDPM classifications with evidence citations	MDS coordinators, clinical reimbursement directors	DolphinCare, Anthuria, Nanonets Health, PointClickCare PDPM Coach
CDI and compliance monitoring	Audit documentation completeness and consistency; prepare ADR/audit packages	Compliance officers, DONs, revenue cycle teams	Anthuria's ADR module, KLAS-tracked CDI category tools
EHR-embedded AI/analytics	Native platform features for risk prediction, compliance flags, referral intake	Facility administrators, clinical directors	PointClickCare Chart Advisor, CareComply, Referral Advisor; MatrixCare Clinical Advanced Insights

The table illustrates that despite marketing language that often blends these categories together, the underlying software differs in where it sits in the documentation lifecycle: scribes generate the raw note, coding assistants translate that note into regulatory codes, CDI tools audit the result, and embedded analytics act on the aggregated data afterward. A facility evaluating "AI documentation" should first identify which stage of that lifecycle it is trying to improve, since a scribe alone does not solve an MDS coding accuracy problem, and a coding assistant alone does not reduce the time a nurse spends charting at the bedside.

AI-Assisted MDS Completion and PDPM Coding Software

The MDS and PDPM coding workflow is arguably the highest-stakes documentation task in a skilled nursing facility, because a single miscoded item can simultaneously create compliance exposure and change a facility's Medicare reimbursement. Under PDPM, five case-mix-adjusted components—physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), nursing, and non-therapy ancillary (NTA)—collectively determine a five-character Health Insurance Prospective Payment System (HIPPS) billing code derived from MDS item responses (Source: cms.gov). The mandatory five-day scheduled PPS assessment must be completed with an Assessment Reference Date (ARD) falling within days one through eight of a covered stay (Source: cms.gov), and facilities may optionally complete an Interim Payment Assessment (IPA) to report a change in a resident's clinical classification during the stay, a decision left to the provider and one that changes payment from the ARD forward until the end of the Part A stay (Source: cms.gov). CMS has stated that the PDPM assessment schedule "is significantly more streamlined and simple to understand" than its RUG-IV predecessor, which required frequent scheduled and unscheduled assessments to track highly variable therapy-utilization characteristics (Source: cms.gov). Even so, under RUG-IV no more than 25 percent of therapy services per discipline could be delivered in group settings, a compliance threshold PDPM retained in modified form by combining concurrent and group therapy into a single 25 percent limit (Source: cms.gov). MDS coordinators still describe reviewing hundreds of pages of hospital records to identify every diagnosis, comorbidity, and functional detail that changes an item response.

AI-assisted MDS software addresses this specific pain point: it scans admission packets, physician orders, therapy notes, and the electronic medication administration record (eMAR), then proposes item-level codes with a citation back to the source document. **Nanonets Health**, for instance, reports that its PDPM tool drives a 60 percent reduction in time spent on MDS preparation (Source: nanonets.health). **DolphinCare** positions its product as an "auto-suggestor" that overlays the EHR and "scrapes all sources" in real time while leaving an audit trail for every suggestion (Source: dolphincare.ai).

Embedded alternatives exist inside the dominant SNF EHR platforms. **PointClickCare PDPM Coach**, an add-on module inside the PointClickCare EHR, provides real-time guidance during the critical five-day admission MDS completion process (Source: intuitionlabs.ai), automates the collection of Medicare Part A physician certifications via SMS, and reinforces PDPM best practices as a training tool; customers have reported "a significant average increase in Medicare revenue per patient day" after adoption (Source: intuitionlabs.ai). The module's own listed limitations include that it requires use of the core PointClickCare EHR platform and inherits some of that parent platform's general complexity (Source: intuitionlabs.ai). On

January 13, 2026, PointClickCare announced the upcoming availability of **Referral Advisor**, an AI-powered tool designed to streamline referral intake and provide clinical and financial insights for admissions decisions. PointClickCare described it as its newest AI offering and said it would launch later that month to selected skilled nursing organizations (PointClickCare.

Because these tools directly influence Medicare billing codes, they inherit the compliance exposure of the underlying MDS and PDPM system. A 2025 OIG audit of Pinnacle Multicare Nursing and Rehabilitation Center found that the facility incorrectly billed Medicare when the medical record did not support the assigned reimbursement rate code, when services were provided to individuals who did not require skilled nursing care, and when documentation requirements were not met, producing an estimated overpayment of at least $31.2 million (Source: oig.hhs.gov). For this reason, most MDS-focused AI vendors emphasize evidence citation and human review rather than autonomous coding. Lime Health AI, for example, states that "a certified coder reviews every note, ICD-10 code, and MDS-relevant field before submission to your EHR. AI suggests; a human verifies," describing this as standard with every plan and syncing directly to PointClickCare, MatrixCare, and Netsmart (Source: getlimeai.com) (Source: getlimeai.com).

AI Scribes and Ambient Documentation for Nursing Homes

Ambient AI scribes address a different problem than coding assistants: the raw time nurses and physicians spend typing or dictating notes during and after a resident encounter. In skilled nursing, this burden compounds because clinicians across multiple disciplines—physicians, nurse practitioners, physician assistants, nurses, and therapy staff—often document for the same resident on the same day. DevXT markets its **NurseXT** product specifically on speed, claiming it turns "a 30-minute nursing note into 90 seconds" (Source: devxt.com), with a reported 75 percent reduction in charting time (Source: devxt.com).

For post-acute settings specifically, scribes must be built to understand SNF-specific note types: admission and readmission assessments, interval progress notes tied to a physician's rounding schedule, and hospital-to-SNF transition summaries. Twofold Health's SNF product line, for example, is designed to "draft admit notes for new SNF residents with clear problems, baseline status, meds, and plan, based on a short clinician recap" and to "summarize hospital discharge context and translate it into actionable SNF documentation for post acute transitions of care," while also supporting interdisciplinary teams across "physicians, NPs, PAs, nurses, and therapy partners working inside skilled nursing facilities," with pricing that begins at a free one-week trial followed by $19 for the first month (Source: trytwofold.com) (Source: trytwofold.com) (Source: trytwofold.com). Because these tools handle protected health information, a signed BAA and appropriate safeguards are baseline requirements, but do not by themselves establish that a product or deployment is HIPAA compliant: Twofold Health states that "all PHI handled by Twofold is encrypted and protected under a signed Business Associate Agreement (BAA) to support HIPAA compliant skilled nursing workflows" (Source: trytwofold.com), a requirement rooted in the HIPAA Privacy Rule's mandate that a covered entity obtain written assurances, "whether in the form of a contract or other agreement," that any business associate handling protected health information will safeguard it appropriately (Source: hhs.gov). Under that rule, a business associate is broadly defined as any "person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity," a definition that plainly captures AI scribe and coding vendors processing resident PHI (Source: hhs.gov).

Independent evidence on ambient scribe accuracy, drawn primarily from outpatient and hospital settings rather than SNFs specifically, counsels caution. A 2025 instrument-validation study published in the Journal of Medical Internet Research tested two commercially available ambient digital scribe products against 11 simulated outpatient encounters and found 127 total errors across 44 draft notes, an average of 2.9 errors per note, with errors present in 70 percent of all notes generated (Source: jmir.org). Error types differed significantly between the two products tested, according to a Fisher exact test reported in the study (P = .002) (Source: jmir.org). Omission errors, information a clinician said but the AI failed to capture, were the most common category and are also the hardest for a reviewing clinician to catch, since identifying an omission requires the clinician to recall details from memory rather than simply recognizing an error in the displayed text (Source: jmir.org). The same study's authors note that, absent a standardized national evaluation framework, "health care facilities currently bear the burden of testing and reporting these results in the United States" (Source: jmir.org).

A broader 2025 systematic review of eight AI scribe intervention studies across clinical settings, registered in advance with PROSPERO under registration number CRD42024619680, concluded that "AI scribes show promise in improving documentation efficiency and clinician workflow, although the evidence remains limited and heterogeneous," and specifically noted that "accuracy and consistency can vary significantly depending on the specific technology, model training data, and implementation approach" (Source: pmc.ncbi.nlm.nih.gov) (Source: pmc.ncbi.nlm.nih.gov) (Source: pmc.ncbi.nlm.nih.gov). That review also documented a large-scale hospital-system pilot at The Permanente Medical Group, which found that ambient AI scribe technology "improve[d] physician engagement, enhance[d] the quality of clinical documents, and improve[d] workflow efficiency" (Source: pmc.ncbi.nlm.nih.gov), while cautioning that "the human element remains crucial, particularly for overseeing more complex cases" (Source: pmc.ncbi.nlm.nih.gov). The same review cited Canadian Medical Association data showing 60 percent of physicians report administrative burden as a

direct contributor to declining mental health, and that Canadian physicians alone spend approximately 18.5 million hours a year on unnecessary administrative tasks, the equivalent of 55.6 million patient consultations, framing the scale of the problem AI scribes are attempting to solve even where the evidence for the solution itself remains preliminary (Source: pmc.ncbi.nlm.nih.gov) (Source: pmc.ncbi.nlm.nih.gov).

Regulators have begun to respond to this accuracy gap. The European Union's Artificial Intelligence Act entered into force on August 1, 2024, but its obligations apply on a phased schedule; that date did not make every clinical AI safety requirement immediately applicable. Whether an SNF documentation product is subject to the Act's high-risk requirements depends on its intended purpose and legal classification, and deployers should verify the applicable transition date and obligations for the specific system (European Commission AI Act overview; entry-into-force notice. In the United States, facilities should independently evaluate clinical accuracy, regulatory status, and deployment risk rather than assume a product has undergone a uniform nationwide pre-market AI-safety review.

Clinical Documentation Improvement and EHR-Embedded AI

Clinical documentation improvement, a discipline with deep roots in acute-care revenue cycle management, is migrating into skilled nursing as EHR vendors add native AI features rather than requiring operators to purchase separate point solutions. This matters because most SNFs run their clinical and financial operations on one of a small number of dominant platforms, principally PointClickCare, MatrixCare, and Netsmart myUnity, making embedded AI a lower-friction path to adoption than a standalone scribe or coding assistant that must integrate separately with each EHR.

PointClickCare, described by its own marketing as "a leading cloud-based electronic health record (EHR) and financial management platform for the long-term and post-acute care (LTPAC) industry," reports more than 10,000 customers (Source: intuitionlabs.ai). Its AI and advanced analytics suite includes Chart Advisor for AI-powered risk management and CareComply for AI-powered compliance monitoring, both designed to "proactively protect margins and mitigate risk exposure" (Source: intuitionlabs.ai). Subscription pricing is quote-based, but an estimated starting price for a small facility runs $500 to $1,000 per month, with large-scale, multi-facility implementations ranging from $50,000 to more than $200,000 (Source: intuitionlabs.ai).

MatrixCare's Clinical Advanced Insights (CAI) platform, introduced in 2021, is the most rigorously studied embedded AI feature identified in this research. A peer-reviewed study published in the Journal of the American Medical Directors Association compared 94 skilled nursing communities using an AI- and machine-learning-enhanced EHR against 124 communities using a standard EHR without the AI component, and found that 16 of 18 tracked quality measures showed statistically greater improvement in the AI-enabled group (Source: skillednursingnews.com). Specifically, the AI-enabled group saw a 9 percent greater reduction in major falls and a 22 percent greater reduction in residents needing help with activities of daily living, along with improvements in depressive symptoms and antipsychotic medication use (Source: skillednursingnews.com). MatrixCare's own head of nursing and clinical informatics for senior living and long-term care described being "surprised by the fact that it impacted four quality metrics" beyond the falls outcome the platform was originally built to address, adding that in each affected measure, "items were identified early and addressed early" because machine learning enables a proactive rather than reactive posture (Source: skillednursingnews.com) (Source: skillednursingnews.com), a rare instance of a vendor publicly noting a result larger than expected rather than only claims that confirm the product's marketing thesis.

Broader physician and nursing sentiment toward embedded AI is mixed but trending positive. Citing a 2025 American Medical Association survey, industry reporting found that two in three physicians were using health AI in some form as of early 2025 (Source: skillednursingnews.com), yet a 2024 McKinsey survey of more than 7,000 nurses found 42 percent hopeful that AI would improve care quality, while 23 percent reported discomfort with what AI could mean for patient care (Source: skillednursingnews.com). MatrixCare's VP of product management for data and AI/ML attributes some resistance to "previous misconceptions" that AI tools are technical or hard to use, arguing that "most of the modern data and AI solutions are seamless in your day-to-day workflows" (Source: skillednursingnews.com), a split that echoes the KLAS Arch Collaborative's finding that nurses want streamlined documentation but remain wary of any tool that adds, rather than removes, review burden.

CDI functionality also extends to audit preparation, a task that is especially acute in skilled nursing given the volume of Medicare Additional Documentation Requests SNFs receive. Anthuria's ADR module is built to "compile audit packages in minutes," pulling admission assessments, discharge summaries, physician orders, nursing notes, and the MDS assessment itself into a single downloadable package for submission to a Medicare Administrative Contractor (Source: anthuria.ai). In the Pinnacle Multicare audit, OIG found that the facility did not consistently follow its procedures for complying with Medicare documentation requirements (Source: oig.hhs.gov).

Implementation Guidance: Selecting, Deploying, and Governing AI Documentation Tools

Selecting an AI documentation tool for a skilled nursing facility requires evaluating criteria that go beyond the efficiency claims most vendor sites lead with. Based on the products and regulatory context examined in this research, the following criteria are the most consequential for a buying decision:

- **EHR integration model.** Confirm whether the tool integrates natively (PointClickCare Chart Advisor, MatrixCare CAI), syncs bidirectionally with the EHR (Lime Health AI, DolphinCare), or requires manual copy-paste (some lower-cost scribes); integration depth materially affects daily workflow friction.
- **Human-in-the-loop coding review.** For any tool touching MDS or PDPM codes, confirm a licensed clinician or certified coder reviews AI suggestions before submission, as Lime Health AI's model illustrates (Source: getlimeai.com), since unreviewed AI-suggested codes create the same audit exposure as unreviewed human-entered codes.
- **Evidence traceability.** Favor tools that link every suggested code or note element back to its source document, as Anthuria and DolphinCare both emphasize, since traceability is what allows a facility to defend a code during an ADR or CMS audit (Source: anthuria.ai).
- **HIPAA business associate status.** Any vendor processing protected health information on a covered entity's behalf is a business associate under the HIPAA Privacy Rule and must sign a written agreement describing permitted uses of that data and requiring appropriate safeguards.
- **Accuracy measurement methodology.** Ask vendors how "accuracy" is defined and measured; the 97 percent PDPM case-mix classification accuracy claimed by Nanonets Health (Source: nanonets.health) measures something different than the error rates found in independent, peer-reviewed testing of ambient scribes generally (Source: jmir.org).
- **Onboarding timeline and change management.** DevXT's NurseXT reports most facilities live within two weeks of purchase (Source: devxt.com), but the KLAS Arch Collaborative's research on nursing documentation optimization more broadly finds that sustained success depends less on the technology itself than on executive sponsorship, multidisciplinary governance, and frontline nurse engagement throughout rollout (Source: klasresearch.com).
- **Total cost of ownership.** Beyond subscription fees, SNF operators should budget for implementation; one market analysis estimates the total cost of purchasing, implementing, and installing EHR-adjacent software for a provider can range from $15,000 to $70,000, with monthly operational costs for cloud-based systems commonly running $200 to $3,000 depending on scale (Source: grandviewresearch.com) (Source: grandviewresearch.com).

Governance does not end at procurement. Because MDS and PDPM data flow directly into Medicare reimbursement and the CMS Five-Star Quality Rating System, which CMS created in 2008 and which rates nursing homes from one to five stars across health inspections, staffing, and quality measures (Source: cms.gov) (Source: cms.gov), any AI-assisted coding change should be periodically audited against the same standard CMS itself applies during targeted reviews, such as the schizophrenia-coding audits it has run since 2023. One of the quality measures feeding directly into that star rating is the percentage of long-stay residents receiving antipsychotic drugs, a measure that specifically excludes residents diagnosed with schizophrenia, Huntington's disease, or Tourette syndrome, which is precisely why CMS is concerned that erroneous schizophrenia coding could mask a facility's true antipsychotic usage rate (Source: cms.gov). LeadingAge, a national association representing nonprofit aging-services providers, advises members to "start by auditing your MDS records," since many EHR systems already include the reporting features needed to run a diagnosis-based audit before CMS runs one for them (Source: leadingage.org), and reports hearing "anecdotally that few nursing homes are passing" the schizophrenia audits once selected, largely because facilities lack documentation showing how a clinician arrived at the diagnosis in the first place (Source: leadingage.org), which is precisely the kind of evidentiary gap that an AI tool emphasizing source traceability is designed to close, provided facilities actually use that traceability for internal audit rather than only for initial coding speed.

An independent perspective can be useful because software vendors have an incentive to emphasize their own accuracy and ROI claims. IntuitionLabs is not an SNF documentation vendor, and its website describes the company as focused on pharmaceutical and life-sciences organizations rather than skilled nursing operators (Source: intuitionlabs.ai). Accordingly, this article should be read as market analysis, not as evidence of IntuitionLabs' experience advising SNFs. Facilities should validate product claims, BAA scope, EHR integration, clinical governance, and audit controls directly with vendors and qualified long-term-care, legal, compliance, and clinical advisers.

Data Analysis and Evidence

Quantifying the documentation burden that AI tools are meant to address, and the evidence for whether they succeed, requires triangulating across peer-reviewed research, industry survey data, and vendor-reported outcomes. Each source has known limitations: peer-reviewed studies are more rigorous but rarer and slower to reflect the newest AI tools; industry surveys such as the KLAS Arch Collaborative aggregate large real-world samples but are sponsored by health-IT-adjacent organizations; and vendor-reported statistics, while directionally informative, are self-selected and rarely independently audited.

On the underlying burden, the peer-reviewed literature is consistent. Nurses have been shown to document between 600 and 800 discrete data points per 12-hour shift, equivalent to one entry every 1.11 minutes (Source: pmc.ncbi.nlm.nih.gov) (Source: pmc.ncbi.nlm.nih.gov), and the U.S. Surgeon General's Advisory on health worker burnout found nurses spend roughly 40 percent of each shift on documentation (Source: aacn.org).

Documentation burden has a measurable relationship to clinician wellbeing: a validated cross-sectional survey found a weak-to-moderate correlation between documentation burden and clinician burnout syndrome, and separately found that poor EHR usability is independently associated with both documentation burden and burnout (Source: pmc.ncbi.nlm.nih.gov), against a backdrop in which approximately 38 percent of nurses report experiencing at least one symptom of burnout (Source: pmc.ncbi.nlm.nih.gov).

The KLAS Arch Collaborative's 2025 report, drawing on responses from 80,147 acute care nurses across 179 organizations surveyed between September 2022 and September 2025, found that 79 percent of nurses report losing time to unproductive charting, defined as duplicative or unhelpful documentation, and that acute care nurses ask for streamlined or reduced charting twice as often as any other single EHR enhancement request (Source: klasresearch.com) (Source: klasresearch.com) (Source: klasresearch.com). The Arch Collaborative itself draws on data from more than 300 healthcare organizations and over 600,000 clinicians who have completed its standardized EHR-experience survey to date (Source: klasresearch.com). That report is drawn from acute-care hospital nurses rather than skilled nursing facilities specifically, a distinction this analysis flags honestly since no comparably large SNF-specific dataset was identified in this research, though qualitatively similar dynamics, duplicative flowsheet entries, inconsistent workflows across shifts, and excessive required fields, appear in the vendor and trade-press material examined for the SNF setting specifically, and critical care nurses specifically report the highest rates of unproductive charting time among all acute-care specialties surveyed (Source: klasresearch.com).

Documentation-burden reduction initiatives that succeed, whether AI-driven or not, appear to share common traits. At Mercy, a 50-hospital health system, a two-year workflow redesign initiative saved an average of 32 minutes of charting per nurse per day (Source: klasresearch.com); at Wooster Community Hospital Health System, eliminating 96 redundant documentation fields saved more than 15,000 nursing hours annually (Source: klasresearch.com); and at Children's Hospital of Philadelphia, a two-year Epic optimization project generated more than $21 million in cost savings (Source: klasresearch.com). None of these three case studies involved generative AI; they involved workflow redesign and field elimination, a reminder that AI documentation tools are one lever among several, not a replacement for underlying process discipline. Separately, one large academic medical center reported reducing time spent on documentation by 15 percent for ICU nurses and 22 percent for medical-surgical nurses through a dedicated task force, translating to an additional 30,000 hours of direct patient care capacity annually across the system (Source: aacn.org) (Source: aacn.org).

Table 2 below compares vendor-reported outcome statistics against the independently measured findings discussed throughout this report, to make the gap between marketing claims and peer-reviewed evidence explicit.

METRIC	VENDOR-REPORTED (SOURCE)	INDEPENDENTLY MEASURED (SOURCE)
Charting/documentation time reduction	75% less charting time, NurseXT (Source: devxt.com); 60% reduction in MDS prep time, Nanonets (Source: nanonets.health)	15-22% reduction via non-AI workflow redesign, academic medical center (Source: aacn.org); 32 minutes/nurse/day, Mercy Project ANEW (Source: klasresearch.com)
PDPM classification accuracy	97% PDPM classification accuracy, Nanonets (Source: nanonets.health)	No directly comparable independent result identified
Ambient-scribe note accuracy	Not reported here	127 errors across 44 draft notes (70% of notes contained errors), JMIR ambient scribe validation study (Source: jmir.org)
Financial/reimbursement impact	$2,400-$6,250/month incremental revenue, DolphinCare (Source: dolphincare.ai)	16 of 18 quality measures improved (not directly revenue), MatrixCare CAI study, JAMDA-published (Source: skillednursingnews.com)
Clinical outcome impact	Not typically quantified by scribe/coding vendors	9% greater fall reduction; 22% greater ADL-independence improvement, MatrixCare CAI study (Source: skillednursingnews.com)

The comparison in Table 2 shows a consistent pattern: vendor statistics tend to describe process metrics (time saved, accuracy percentages, revenue captured) measured internally and without a published control group, while the small set of independently measured or peer-reviewed results available describe either accuracy problems the vendor statistics do not surface (the JMIR error-rate study) or genuine clinical-outcome improvements

measured against a real control group (the MatrixCare JAMDA study). Neither category of evidence should be dismissed outright; vendor telemetry at scale has informational value. However, a facility evaluating these tools should assess evidence within the same product category and task, because the JMIR ambient-scribe study cannot validate or refute a PDPM-classification accuracy claim.

Market-level and workforce-cost data corroborate that this is a growing but still-consolidating software category layered on top of a workforce under sustained cost pressure. The U.S. long-term care software market, of which AI documentation tools are a growing subset, was valued at $2.41 billion in 2025 and is projected to reach $4.11 billion by 2033, a 6.92 percent compound annual growth rate (Source: grandviewresearch.com), with skilled nursing facilities and nursing homes representing the largest single end-use segment by market share in 2025 (Source: grandviewresearch.com) and the cloud-based delivery model holding a 41.55 percent share of the overall market (Source: grandviewresearch.com). On the labor-cost side of the ledger that AI documentation tools are meant to offset, SNF hourly wages rose an average of $3.73, or 18.2 percent, in a single reported period, reaching a total average hourly wage of $24.25 (Source: pmc.ncbi.nlm.nih.gov), and contracted agency RNs commanded an average hourly rate of $54.33 versus $42.31 for employed RNs, a 28.4 percent premium that has made agency staffing an expensive stopgap for documentation and care gaps alike (Source: pmc.ncbi.nlm.nih.gov).

Case Studies and Real-World Examples

MatrixCare Clinical Advanced Insights: A Peer-Reviewed, Controlled Comparison

The most methodologically rigorous evidence identified in this research comes from a study published in the Journal of the American Medical Directors Association, which compared 94 skilled nursing communities using MatrixCare's AI- and machine-learning-enhanced EHR against 124 communities using a standard, non-AI-enabled EHR (Source: skillednursingnews.com). Across 18 tracked quality measures, the AI-enabled group showed statistically greater improvement on 16, including a 9 percent greater reduction in major falls and a 22 percent greater reduction in residents requiring assistance with activities of daily living, alongside improvements in depressive symptoms and antipsychotic medication use (Source: skillednursingnews.com). The study's authors attributed the effect to the AI system's ability to identify resident assessment protocol triggers for clinical modification "through real-time monitoring and response," while cautioning that "further research is needed" (Source: skillednursingnews.com). This case is notable for what it is not: it is not a vendor case study built around a single flagship facility, but a controlled comparison across 218 total communities, giving it more external validity than the single-facility testimonials common elsewhere in this market.

DolphinCare's Multi-Facility MDS Deployment

DolphinCare, an AI-powered MDS auto-suggestion tool, reports usage across more than 145 skilled nursing facilities as of its most recent published figures (Source: dolphincare.ai). Named customer testimonials on the company's site include Paramount Care Centers, whose VP of Clinical Reimbursement described the decision to expand DolphinCare "for all of our facilities, after they ran reports and showed us what we missed, even with our high-level scrubbing team," adding that the tool was "saving MDS resources, both time and money, that would otherwise be spent on MDS consultants and scrubbers" (Source: dolphincare.ai). This case illustrates a reported adoption pattern in the MDS coding assistant category: initial deployment at a subset of facilities within a multi-site operator, followed by expansion after internal review indicated that the tool caught reimbursement-relevant details the existing scrubbing process had missed.

CMS's Schizophrenia-Coding Audits: A Regulatory Response to MDS Coding Risk

Since 2023, CMS has conducted targeted, off-site audits of schizophrenia coding on the MDS, motivated by concern that some facilities were erroneously coding residents as having schizophrenia in order to exclude them from the antipsychotic-medication quality measure that feeds into the Five-Star Quality Rating System (Source: cms.gov). Facilities found to have inaccurately coded schizophrenia have their quality-measure star ratings downgraded or suppressed on the public Nursing Home Care Compare website (Source: cms.gov). LeadingAge, the national nonprofit aging-services association, reports that these audits target facilities "with high numbers of residents for which no schizophrenia diagnoses were coded on admission assessments but were later coded on subsequent assessments," and that CMS demands "a clear path from Point A to Point B," rejecting a bare diagnosis code or symptom checklist as insufficient support (Source: leadingage.org) (Source: leadingage.org). This regulatory case is a direct illustration of why evidence-linked AI coding tools, which cite the specific chart location supporting every suggested code, address a real compliance need rather than a hypothetical one.

Pinnacle Multicare: 2025 OIG Audit Findings

A 2025 OIG audit of Pinnacle Multicare Nursing and Rehabilitation Center found that the facility failed to comply with Medicare payment requirements on 99 of 100 sampled claims for skilled nursing services provided during 2020 and 2021, producing estimated overpayments of at least $31.2 million (Source: oig.hhs.gov). OIG attributed the failures to the facility's clinical and billing staff not consistently following its own procedures for assigning reimbursement rate codes and verifying that residents required skilled nursing services, and recommended the facility refund the full $31.2 million, conduct internal audits of claims outside the sampled period, and retrain clinical and billing personnel (Source: oig.hhs.gov). Notably, Pinnacle "did not concur with any of our recommendations" (Source: oig.hhs.gov); the audit's findings and recommendations addressed the facility's claims, procedures, and staff training.

PointClickCare Referral Advisor: AI Expansion into Pre-Admission Documentation

PointClickCare announced Referral Advisor on January 13, 2026, with availability planned later that month for selected skilled nursing organizations. The vendor said the tool would streamline referral intake and provide instant clinical and financial insights to support admissions decisions (PointClickCare. The announcement supports a January 2026 launch timeline; it does not establish that Referral Advisor or a same-named predecessor launched in January 2024. Separately, the broader post-acute software market includes interoperability efforts such as an announced bidirectional EHR integration between CharmHealth and PointClickCare in January 2026 (Source: grandviewresearch.com).

Implications and Future Directions

Several trends emerge from this research that should shape how SNF operators plan AI documentation adoption over the next several years. First, the center of gravity is shifting from standalone point solutions toward embedded EHR features. PointClickCare's Chart Advisor, CareComply, and Referral Advisor, and MatrixCare's Clinical Advanced Insights, all ship as native platform capabilities rather than third-party add-ons, and the broader market data supports this trajectory: cloud-based delivery already commands 41.55 percent of the U.S. long-term care software market (Source: grandviewresearch.com), a delivery model that favors vendors able to bundle AI into an existing subscription rather than requiring a separate integration project.

Second, the evidence base for clinical and quality outcomes is likely to strengthen faster than the evidence base for pure documentation-time savings, because outcome measures like falls and antipsychotic use are already tracked in CMS quality reporting infrastructure and lend themselves to the kind of controlled, multi-facility comparison used in the MatrixCare JAMDA study (Source: skillednursingnews.com), while time-savings claims remain harder to verify independently and will likely continue to rely on vendor-reported telemetry for the near term.

Third, regulatory scrutiny of AI-assisted coding accuracy will likely intensify rather than relax. The precedent set by CMS's schizophrenia-coding audits, which apply equally regardless of whether a human or an AI tool originally suggested the code (Source: cms.gov), suggests that CMS's audit posture treats the origin of a code as irrelevant to whether it is defensible; only the underlying clinical evidence matters. The Pinnacle Multicare audit documents OIG's findings on claims from one facility during the audited period; it does not provide evidence about outcomes for facilities using AI coding assistants (Source: oig.hhs.gov).

Fourth, workforce dynamics will continue to shape adoption incentives even as the acute staffing crisis of 2020 to 2022 eases. The nursing home sector added 40,700 jobs in 2025 and temporary staffing agency usage has fallen roughly 44 percent since the fourth quarter of 2022 (Source: ahcancal.org), and 62 percent of providers say their overall workforce situation has improved over the past year while 60 percent have added new or expanded training programs (Source: ahcancal.org) (Source: ahcancal.org); yet 90 percent of providers still describe recruitment as difficult and the sector's overall headcount remains 1.7 percent below pre-pandemic levels (Source: ahcancal.org) (Source: ahcancal.org). AI documentation tools that meaningfully reduce time spent on charting are likely to remain attractive as a retention lever even as pure staffing shortage metrics improve, since the KLAS Arch Collaborative research links high unproductive-charting time directly to elevated burnout and turnover risk among nurses (Source: klasresearch.com).

Finally, independent advisory capacity will likely play a growing role as the number of point solutions multiplies. With dozens of vendors now targeting MDS coding, ambient scribing, and CDI in skilled nursing specifically, operators evaluating this landscape as part of a broader enterprise data and compliance strategy, rather than a single software purchase, may benefit from advisory relationships with firms that have no stake in which specific documentation vendor a facility selects, a role life-sciences and healthcare AI consultancies increasingly fill alongside their more traditional enterprise-integration and Veeva-ecosystem work; intuitionlabs.ai, for instance, describes itself as an "Official Veeva Vault CRM X-Pages Partner" offering "expert implementation, customization, and extensions for Veeva CRM, Vault, X-Pages/MyInsights, and Nitro" for regulated life-sciences and healthcare organizations (Source: intuitionlabs.ai).

Frequently Asked Questions (FAQs)

What is AI documentation for skilled nursing facilities?

AI documentation refers to software that uses artificial intelligence, typically large language models or machine learning classifiers, to assist with clinical charting, MDS assessment completion, PDPM coding, or documentation quality auditing in a skilled nursing facility. It spans ambient AI scribes, MDS/PDPM coding assistants, CDI tools, and AI features embedded in EHR platforms like PointClickCare and MatrixCare, as detailed in the taxonomy section above.

What is MDS documentation software?

MDS documentation software helps MDS coordinators complete the federally mandated Minimum Data Set assessment, a core set of screening, clinical, and functional status elements required for every Medicare- or Medicaid-certified nursing home resident (Source: aapacn.org). AI-enabled versions, such as DolphinCare, Anthuria, and Nanonets Health, add automated code suggestions with evidence citations drawn from the resident's chart.

What are PDPM AI tools?

PDPM AI tools apply artificial intelligence to the Patient-Driven Payment Model, the CMS case-mix classification system that has determined SNF Medicare Part A reimbursement since October 1, 2019 (Source: cms.gov). These tools typically scan clinical documentation to identify Non-Therapy Ancillary (NTA) comorbidities and Interim Payment Assessment (IPA) triggers that affect a resident's case-mix classification and reimbursement rate (Source: cms.gov).

Can AI reduce nursing documentation burden in a nursing home?

Evidence suggests it can, but the size of the effect is not yet established by controlled, peer-reviewed SNF-specific research. Vendors report large reductions in specific workflows, while the strongest independent evidence to date, the MatrixCare JAMDA-published study, measures clinical outcome improvement rather than a directly comparable time-savings figure (Source: skillednursingnews.com).

Is an AI scribe for a nursing home HIPAA compliant?

No product is automatically “HIPAA compliant.” When an AI-scribe vendor creates, receives, maintains, or transmits PHI on behalf of a covered entity or business associate, a HIPAA-compliant Business Associate Agreement is generally required, but a BAA alone is not sufficient. The facility and vendor must also comply with applicable Privacy, Security, and Breach Notification Rule obligations, including permitted uses and disclosures, risk analysis, access and security controls, subcontractor terms, and incident procedures (HHS cloud-computing guidance; HHS sample BAA provisions. Facilities should also assess applicable state privacy and recording-consent laws with qualified counsel.

Is automated MDS coding accurate enough to rely on without human review?

No AI documentation vendor examined in this research recommends fully autonomous MDS coding without clinician or certified coder review; Lime Health AI, for instance, states explicitly that "AI suggests; a human verifies" as a standard feature of its product (Source: getlimeai.com). Given that a 2025 peer-reviewed study found errors in 70 percent of ambient-scribe-generated draft notes in a controlled setting (Source: jmir.org), human review of AI-generated clinical documentation and coding suggestions remains a compliance necessity, not merely a best practice.

How does clinical documentation improvement (CDI) differ from an AI scribe in a skilled nursing facility?

An AI scribe generates the initial draft note from a spoken encounter, while CDI software audits documentation after it exists, checking for missing certifications, inconsistent coding, or gaps that would fail a Medicare audit (Source: klasresearch.com). Anthuria's ADR module is one example built specifically to assemble audit-ready documentation packages (Source: anthuria.ai).

Conclusion

AI documentation has become a substantive, if still maturing, category within skilled nursing facility operations, spanning ambient scribes that draft encounter notes, MDS and PDPM coding assistants that surface reimbursement-relevant evidence, clinical documentation improvement tools that audit completeness, and AI features now built directly into the dominant SNF EHR platforms. The underlying problem these tools address is well

established in the peer-reviewed literature: nurses spend roughly 40 percent of a shift on documentation and generate hundreds of discrete data points per shift, a burden CMS itself has tried to address through regulatory simplification even before AI tools entered the market.

The evidence for AI documentation's effectiveness is genuinely mixed rather than uniformly positive. Vendor-reported statistics describe large efficiency and revenue gains, while the limited independent, peer-reviewed evidence available shows both meaningful clinical-outcome improvement, in the controlled MatrixCare comparison, and material accuracy risk, in the JMIR ambient-scribe error study. The Pinnacle Multicare audit and CMS's schizophrenia-coding audits concern distinct documentation and coding issues within Medicare and the CMS Five-Star Quality Rating System. Operators evaluating this category should weight peer-reviewed and controlled evidence more heavily than single-vendor telemetry, insist on human review and evidence traceability for any tool touching billing codes, confirm HIPAA business associate agreements before any resident data is processed, and treat AI documentation adoption as a governance project requiring the same executive sponsorship and multidisciplinary oversight that non-AI documentation optimization initiatives have already shown to succeed. Done well, AI documentation tools can meaningfully reduce the administrative load that competes with direct resident care in skilled nursing facilities; done without adequate review and audit discipline, they simply automate the same coding and compliance risks that have long existed in this heavily regulated setting.

Tags: ai documentation, skilled nursing facilities, mds documentation software, pdpm ai tools, ai scribe nursing homes, clinical documentation improvement, automated mds coding, ehr ai snf, pointclickcare, matrixcare

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Contact founder Adrien Laurent and team at intuitionlabs.ai/contact for a consultation.

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