DISCHARGE AUDIT

Check (✓) if documentation is present and complete. Leave blank if missing or incomplete. Record NA when not applicable, i.e., Death certificate for resident discharged alive.

AREA OF REVIEW	✓	AREA OF REVIEW	✓
Post-discharge POC complete		Narcotic count records	
Transfer record(s)		MARs/TARs	
Discharge summary completed/signed by physician		Labs/x-ray reports	
Interdisciplinary Discharge Summary		Immunization/vaccination records	
Death certificate (if expired)		Restorative nursing records – evaluations and progress notes	
Order to discharge/release body		SS assessments, history, discharge plan	
Face Sheet/Admission Record		SS progress notes	
PASARR records (if applicable)		Nutrition assessments and progress notes	
Hospitalization records		Dietary progress notes	
Privacy Act Statement – HC Records		Activity assessments and progress notes	
Advance Directive documents		Personal inventory records	
Resident Rights acknowledgement		Master signature sheets (if utilized)	
Code status (DNR/Full code) with order		Soft charts – retrieve and incorporate into closed record	
Capacity statement (per state requirements)		Baseline Care Plan(s)	
Physician orders signed/dated		Comprehensive Care Plan(s)	
Physician progress notes		IDT notes	
Monthly Drug Regimen Review records		Diagnosis sheet(s)/record(s)	
Consultation Reports		PT, OT, SLP, RT evaluations signed by physician	
Nursing Notes and Nursing Assessments		PT, OT, SLP, RT progress notes	
Discharge note, including: • Date/time of discharge • Condition of resident at discharge • Disposition – home/hospital/death, etc. • Physician notified • Legal representative/family notified • Disposition of medications and belongings • If expired, funeral home notification and body removal		PT, OT, SLP, RT discharge notes	
		PT, OT, SLP, RT daily therapy logs	
		Physician certification/recertification for skilled care	
		Advance Beneficiary Notices issued	
		Gradual Dose Reduction records	
		EMR/EHR records archived	
		Facility-specific records:	
MDS records: Admission, quarterly, significant condition change, entry tracking, discharge, death in facility, CAAs, IPA, OSA, Part A Discharge			
Flow records per orders or facility policy • Vital signs records • Weight records • ADL flowsheets • I&O records • Enteral/parenteral records • Diabetes records • Pressure injury flowsheets • Anticoagulant therapy records • Pain flowsheets • Behavior monitor records • _____			
		All records maintained separately from the active record retrieved and incorporated into closed chart (current MAR/TAR records, NA flowsheets, I&O records, diabetes records, restraint records, skin monitor records, behavior records), etc.	

Comments:_____

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Auditor Signature and Title:_____ Date:_____

Date initiated:_____ Date completed:_____ Received by:_____

PART 1 – Original **PART 2 – Nursing ■ SS ■ Dietary ■ Activities ■ Therapy ■**

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed