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Clinical

State Forms:

New: WA Resident Characteristic Roster Form - Now Available

We've added a new tool to help you stay in compliance with Washington state regulations: The **Resident Characteristic Roster** form is now available in the **Clinical > State Forms** section.

What's New:

- **Print Roster for Active Residents**: The new form includes all active residents with completed evaluations. Data is automatically pulled from each resident's last finalized evaluation.
- **Smart Filtering**: Customize your printouts by excluding residents by **Unit Product type/care level**, ensuring only the most relevant records are included.
- **Streamlined Workflow**: After setting up and finalizing evaluations, you can easily print the roster directly from the new **Resident Characteristic Roster** card within the Clinical > State Forms area.

This enhancement simplifies reporting and ensures your team has the accurate documentation needed for regulatory submissions.

New York State Form Printing - Now Available

We've expanded support for **New York State regulatory forms**, allowing clinical providers to generate and print official documentation directly from the platform. This update streamlines compliance workflows and improves data accuracy by auto-populating forms with resident-specific information.

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Supported New York Forms
Evaluation-Based Forms

- **DOH-3122**: Medical Evaluation
  Available directly from the resident's evaluation record.

- **DSS-4449D**: Nursing, Functional, and Social Assessment
  Available directly from the resident's evaluation record.

- **B26a**: Functional Assessment
  Automatically fills from resident and evaluation data. Available directly from the resident's evaluation record.

- **B32-SS**: Social History Outline
  Available directly from the resident's evaluation record.

- **NY Supervisory Note**:
  Automatically fills from resident and evaluation data. Available directly from the resident's evaluation record.

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Supervisory Note

Supervisor's Name: **Myriah Kern**   Client Name: **Kimberly Harrisen**

Date of Supervision: **06/12/2025**   Caregiver's Name: **Morgan**

Caregiver's Discipline: ☒ **RN** ☐ **LPN** ☐ **HHA** ☐ **PCA** ☐ **Other**

Assessment: Client's Condition R/T Caregivers service: **Needs Assistance with dressing and grooming**

Caregiver's Performance R/T care plan: **Able to assist**

Client's / Staff Comments: **none**

Supervisor's Comments: **none**

Caregiver is: ☒ **(a) Punctual** ☐ **(b) Properly Groomed** ☐ **(c) Considerate**

☐ **(d) In compliance w / Infection Control & Standard Precautions**

☐ **(e) Thorough**

Care Plan revised or reviewed: **Reviewed**

On the Job Education provided: **None**

- **DOH-694 PRI**: Pre-Admission Review
  Automatically fills from resident and evaluation data. Available directly from the resident's evaluation record.

NEW YORK STATE DEPARTMENT OF HEALTH
OHSM-Division of Quality and Surveillance for Nursing Homes and ICFs/MR

**Hospital and Community
Patient Review Instrument (HC-PRI)**

RUG II Group (print name)

RHCF Level of Care:
☐ HRF   ☐ SNF

Use with separate Hospital and Community PRI Instructions

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER
   (1-8) 124342

2. SOCIAL SECURITY NUMBER
   (9-17) 741-51-9631

3. OFFICIAL NAME OF HOSPITAL OR OTHER AGENCY/FACILITY COMPLETING THIS REVIEW
   Sanford

4A. PATIENT NAME (AND COMMUNITY ADDRESS IF REVIEWED IN COMMUNITY)
   Harrisen Kimberly

4B. COUNTY OF RESIDENCE Cass

5. DATE OF PRI COMPLETION
   (18-25)   06 - 12 - 2025
   MO DAY YEAR

11A. DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT
   (49-56)06 - 11- 2025
   MO DAY YEAR

11B. DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE)
   (57-64)06 - 11- 2025
   MO DAY YEAR

6. MEDICAL RECORD NUMBER/CASE NUMBER
   (26-34) 1234543

7. HOSPITAL ROOM NUMBER
   (35-39) 123

8. NAME OF HOSPITAL UNIT/DIVISION/BUILDING
   Sanford

12. MEDICAID NUMBER
   (65-75)

13. MEDICARE NUMBER
   (76-85)

14. PRIMARY PAYOR   (86) 1
   1=Medicaid
   2=Medicare
   3= Other

9. DATE OF BIRTH
   (40-47)   -   -
   MO DAY YEAR

10. SEX (48) 2   1=Male
   2=Female

15. REASON FOR PRI COMPLETION (87)
   1. ☒ RHCF Application from Hospital
   2.   RHCF Application from Community
   3.   Other (Specify:)

Resident Demographics & Identity Forms

- **DSS-2949**: Personal Data Sheet
  Backend-generated and accessible from the State Form dropdown.

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- **DSS-2949C**: Custom Personal Data Sheet
  Similar to the DSS-2949, this version supports resident-specific customization.

- **DSS-4449B**: Identifying Data
  Backend-generated with per-resident data pulled from their records.

- **DOH-4397 Part A**: Resident Personal Data
  Available in the State Form dropdown. Each selected resident receives a unique printout.

New York State Department of Health
Division of Assisted Living

ASSISTED LIVING RESIDENCE
RESIDENT PERSONAL DATA FORM

Resident's Name: _Fredricka Alvera_   Facility Name: _Peaceful Pines_

ADMISSION / DISCHARGE INFORMATION

Date of Admission: _05/01/2024_   County: _Brown_

Admitted from: ☐ Own Home ☐ Hospital ☐ NH ☐ OMH ☒ Other (specify): _Adult Day Care_

Address Admitted from (Street, City, State, Zip): _2528 Main Ave West, West Fargo, ND, 58078_

Discharge Date: _06/02/2025_   Discharge to: ☐ Own Home ☐ Hospital ☐ NH ☐ OMH

☒ Other (Specify): _100_

Address Discharged to (Street, City, State, Zip Code): _65 2nd Street, Vermillion, 57069_

Reason for Discharge: _Deceased_

SECTION 1:   PERSONAL DATA

Service Plans & Demographic Enhancements

- **Assisted Living ISP**: Individualized Service Plan
  Built from evaluation data and resident profiles for compliance-ready documentation.

Assisted Living Individualized Service Plan (ISP)

Resident Name: _Fredricka Alvera_   ☒ Female ☐ Male

Date: _06/12/2025_   For: ☒ Initial ☐ Six months ☐ Other _____

Note: Services to be provided and by whom: *Any additional information or change of service on this ISP must be indicated in bold type, capital letters, or by using a different color ink and dated.* **Indicate the reason for any change in service in the last column, and the date of the change.**

Key: N/A = Not Applicable, RA = Resident Aide, N = Nurse, P = Physician, L = Lab Tech, T = Therapist, A = Activities Assistant, M = Med Tech, O = Other

Part 1 - Care Needs

Activity - Check all applicable	Services to be provided	Frequency	By Whom	Changes/Comments
Medical - Nursing				
☒ Lab Test	*Glucose*	*Daily*	RA	

- **Demographic Updates for NY Communities**:
  - **County Field**: Added to the Community Contact section.
  - **Residential Background** & **Occupational/Educational Background**: New demographic fields shown only for New York communities and included in the DOH-4397A form.
  - **Prescription Drug Plan Toggle**: Added to Health Insurance modals; value appears on DOH-4397A.

Easy Access & Role-Based Controls

All forms can be printed either from the **resident's Evaluation tab** or selected via the **State Form modal dropdown**, depending on the form type. Only users with appropriate roles will see and access specific forms to ensure security and compliance.

Plan of Care Configuration Enhancements

We've introduced a comprehensive update to the **Plan of Care** feature in the **Clinical** module, enabling Clinical Managers to better customize, manage, and apply resident-focused care strategies across communities. These improvements span across configuration

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tabs, resident-level service records, and default library content—offering a consistent and scalable experience.

Configuration Management Tools – Now Available

Area of Focus Tab

- **Sidebar for Adding or Editing**: Easily add or modify entries with fields like Description, Category, Status, and linked Expected Outcomes.
- **Smart Search & Validation**: Dropdowns support search; duplicate descriptions trigger validation alerts.
- **Resident Context Placeholder**: Side sheet includes a placeholder for the resident name and toggles for managing visibility.

Expected Outcomes Tab

- **Add & Edit Side Sheets**: Manage resident-specific goals via personalized Description, Type, Status, and Indicator fields.
- **Searchable Table View**: View, sort, and filter Expected Outcomes by status or type (Short-term, Long-term, Intermediate).
- **Historical Integrity**: Inactive outcomes are retained for records while excluded from active selections.

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Category Tab

- **Manage Focus Categories**: Add, edit, and filter categories linked to Areas of Focus, with duplicate-name detection and enabled toggles.
- **Intuitive Navigation**: Each category opens into a sidebar with editable details and save/discard options.

Pre-Configured Defaults for New Communities

To streamline setup for new communities:

- **Default Areas of Focus**: A curated set of focus areas (with categories) is auto-created and enabled.
- **Default Expected Outcomes**: Standardized outcome goals spanning mobility, hygiene, medication, and more.
- **Default Categories**: A comprehensive list including Alcohol Use, Ambulation, and Activities, among others.

These lists help new teams get started quickly and ensure uniformity across clinical operations.

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Resident-Level Plan of Care Integration

Linked Library Fields
- **Area of Focus**: Now linked to the configuration library, supporting text entry and dropdown search. If no match is found, a new entry will be created on-the-fly.
- **Expected Outcomes**: Similarly linked to the configuration tab, enabling flexible goal selection or creation, while retaining record history.

Expandable Menus & Smart Typing
- Users can expand menus, scroll through results, and search live across both fields.
- Auto-fill logic streamlines selection; unmatched text creates a new, trackable entry.

Added Safeguards
- **Confirmation Alerts**: When saving a new Area of Focus or Expected Outcome to the configuration library, users receive a confirmation alert.
- **Role-Based Access**: Only authorized Clinical Managers and designated roles can create, edit, or delete configuration records.

Fixes and Improvements in Clinical Workflow
We've resolved several issues to ensure more accurate documentation, improved care scheduling, and reliable reporting in your clinical workflows.

Event Notes No Longer Duplicated on Save
Previously, saving an event—*even without making any changes*—was mistakenly adding a new note to the record. This has been corrected:
- **What's fixed**: Notes will only be added when actual edits are made.
- **Impact**: Event records remain clean and accurate, avoiding note clutter from unintentional saves.

Daily Cares Now Schedule Properly with Early Occupancy
We identified and resolved an issue where **Daily Cares** were not scheduling if a resident's **Occupancy start date/time** occurred before their **Admission date/time**.
- **What's fixed**: Care tasks will now generate correctly, even if occupancy begins before admission.
- **Impact**: No more manual workarounds—scheduling is aligned with real-world occupancy patterns.

Resident Units Consistently Displayed in Reports
Some users reported missing **unit numbers** in reports like the **Resident Roster**, even when units were correctly assigned in Occupancy.
- **What's fixed**: Resident unit assignments now consistently display across all reports.
- **Impact**: You can trust that unit data shown in reports reflects the actual occupancy setup without requiring manual re-selection.

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Streamlined Order Replacement in Med Manager
We've improved the **Replace Active Order** process in Med Manager to help your clinical teams manage medication orders more efficiently and without gaps in care.

Complete Start/End Transaction in One Step
When replacing an active medication order, the system now supports a full **Start/End transaction** in a single action—eliminating unnecessary steps and ensuring continuity in the order chain.

Key Improvements:
- **One-Click Replacement**: Replace an active order and automatically receive the new one upon confirmation—no separate acknowledgement and actions needed.
- **Smart Flags Supported**: Works seamlessly even when the original order is flagged as **Order Details Mismatch** or **Potential Duplicate**.
- **Clear Confirmation Flow**:
  - Date fields are highlighted for visibility.
  - A confirmation screen prompts the user before finalizing the replacement.
- **No More Order Gaps**: Ensures the old order is properly ended and the new one is received in the same step, maintaining a clean and continuous medication history.

This enhancement reduces administrative overhead and minimizes the risk of medication coverage lapses.

New Post-Validation Status: *Update Accepted*
We've added a new post-validation status in the EMAR system to improve tracking and clarity when pharmacy updates are reviewed and approved.

Smarter Workflow for Order Updates
When pharmacy updates trigger a **details mismatch**—such as changes to instructions or GPI—Med Managers now experience a more streamlined validation process:

Update Accepted Status
- **Displayed in green** for clear visual confirmation.
- Applied after a Med Manager **reviews and accepts** updates to an existing medication order.
- **Persists across page refreshes** and supports consistent follow-up tracking.
- Can be manually overwritten by further validation if needed.

Improved "Replace Active Order" Handling
When using **Replace Active Order**, the system now automatically determines whether a new order chain is required:

- **Existing Medication ID (MEID)**:
  - Users review changes in a confirmation screen.
  - On acceptance, the order is updated and marked as **Update Accepted**.
- **New Medication ID (MEID)**:

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- o Users are prompted to enter start and end dates.
- o A **new order** is created and automatically received, ensuring a clean transition in the medication timeline.

These enhancements ensure that pharmacy-driven updates are properly reviewed, accurately applied, and clearly tracked—all while maintaining the integrity of your medication records.

Enhanced Control Over Medication Instructions Editing

To ensure medication instructions remain consistent with pharmacy-sourced data, we've introduced a new configuration option in the **Manage Orders** workflow.

Edit Restrictions for Pharmacy-Integrated Orders

A new setting—**Allow Instructions Editing for Pharmacy Orders**—gives your organization greater control over how medication instructions are managed.

Key Behavior:
- **When disabled** (default for most setups):
  - o Instructions for **pharmacy-integrated medications** are read-only for all users.
  - o This ensures pharmacy-supplied instructions remain accurate and unaltered.
- **When enabled**:
  - o Editing instructions is allowed, but only based on existing **user permissions**.
  - o Internal orders (non-pharmacy) continue to support instruction edits as usual.

Why this matters:
- Maintains consistency with pharmacy directives.
- Supports compliance and reduces risk of unintended medication changes.
- Offers flexible editing control for organizations needing override capability.

Let us know if you'd like assistance reviewing your current permissions or configuring this setting for your communities.

Admin History Button in Medication Profile

We've made it easier to access administration records directly from the **Medication Profile** with the addition of a new **Admin History** button.

Quick Access to Medication Administration Records

A new **Admin History** button is now available under the **Manage** menu in the **Action** column of each medication entry.

Key Features:
- **Streamlined Navigation**: Opens the Admin History window directly from the Medication Profile—no need to navigate through the MAR Pass screen.

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- **Consistent View**: Displays the same administration details you're familiar with from the MAR Pass screen.
- **Faster Review**: Easily check administration logs, verify dosage times, and audit medication history with fewer clicks.
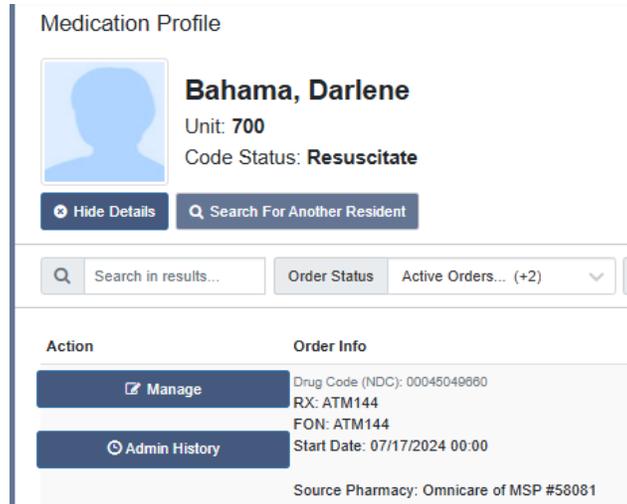
Edit History Tracking for Receive Orders

We've added a new layer of transparency to medication order management with the ability to **track edit history** in the **Receive Orders** process.

Full Visibility into Order Changes

Med Managers can now view a detailed audit trail of all edits made when receiving medication orders—directly within the **Manage Order History** table.

Key Details Captured:

- Date of edit
- Order ID
- Indication
- Form
- Source Pharmacy
- Physician
- Order Type
- Frequency
- Give Amount
- Give Time
- Start Date and Time
- End Date and Time
- Add or Remove Give
- High Alert Medication

- Alternative Administration
- User

Enhanced Formatting:
- Schedule changes are intelligently **combined** for readability.
- Validation changes are handled and displayed as distinct entries for clarity.

This update gives your team deeper insight into how and when orders are modified—supporting accountability, compliance, and confident decision-making.

Improved Order Chain Handling with Pharmacy Updates
We've enhanced the **Order Details Mismatch** workflow in the EMAR system to ensure medication records remain accurate and auditable when updates are accepted from the pharmacy.

New Order Chain Logic with OFON Assignment
When a pharmacy update includes changes to key elements like **instructions** or **GPI**, the system now intelligently determines whether a new order chain should begin:
Key Enhancements:
- **New OFON Assigned When Needed**:
  - If the update contains a **new Medication ID (MEID)**, the current order chain ends and a new one begins.
  - A **new Order FON (OFON)** is generated for the newly created order.
- **Seamless Order Transition**:
  - The existing order is closed properly, and the new order begins immediately—ensuring no gap in medication tracking.
- **Maintained Historical Accuracy**:
  - Both the **original** and **new** orders are visible in administration reports, each with their own FON and full medication history.

This improvement guarantees clear order lineage and accurate reporting, especially when pharmacy-originated updates change the core identity of an order.

Clearer Post-Validation Actions for Potential Duplicates

We've refined the **post-validation action buttons** in the Med Manager interface to make it easier for users to understand and confidently act on **Potential Duplicate** alerts.

Updated Button Labels, Icons, and Order
When reviewing a **Potential Duplicate** order, you'll now see improved visual clarity and logical button placement:
Enhanced Buttons:
- **Keep Both** – Now listed **first**, this button clearly indicates that both orders will remain active.

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- **Replace Active Order** – Suggests a streamlined replacement path for the current order with updated information.
- **Edit Order** – Opens the existing order for manual review and adjustments.
- **Cancel** – Now positioned **last**, providing a clear opt-out option if no action should be taken.

Each button includes **updated icons and color cues** to help users recognize actions at a glance and reduce the risk of unintended changes.

These updates simplify decision-making and improve safety when handling medication order conflicts.

Updated Action Buttons for Order Details Mismatch
To make the **Order Details Mismatch** workflow clearer and more intuitive, we've updated the **post-validation action buttons** in the Med Manager interface.

What's New:
The action buttons now feature clearer labels, consistent icons, and a more intuitive order of appearance:

Renamed & Redesigned:
- **Accept Update** (formerly *Replace Active Order*)
    - o   **Use**: Accept and apply the new order details.
- **Reject Update** (formerly *Reject New Order*)
    - o   **Use**: Discard the proposed update and keep the current order.
- **Edit Order**
    - o   **Use**: Modify the existing order manually.

- **Cancel**
  - **Use**: Exit the update screen without making changes.

New Button Order:
1. **Accept Update**
2. **Edit Order**
3. **Reject Update**
4. **Cancel**

These improvements help reduce confusion, support faster decision-making, and minimize errors during the validation process.

Medication Name Now Displays Without NDC on MAR Pass
We've resolved an issue in the **MAR Pass** workflow that affected the visibility of medication names when an **NDC (National Drug Code)** was missing.

What's Fixed:
- Previously, medications **without an NDC** were not displaying names on the **Med Pass screen**, potentially disrupting clinical workflows and increasing risk.
- With this update, the system now reliably shows the **medication name from the pharmacy message**, even if the NDC is not provided.

Impact for Clinical Teams:
- Ensures **all medications are clearly labeled** during administration.

- Supports safer, more accurate med passes.
- No further manual workaround is required—names appear as expected.

Medication Library Successfully Updated – Medispan Refresh

We've completed the **update of the Medispan drug library**. This update ensures our medication database remains clinically accurate.

What's Included in This Update:

- **New medications** added to the system
- **Discontinued drugs** removed

This update supports accurate medication selection throughout the platform.

Fixes:

EMAR Platform Fixes & Enhancements

We've released a set of updates to improve performance, usability, and reliability throughout the EMAR platform. These improvements address scheduling, medication order processing, test validation, and reporting—ensuring your teams can provide consistent care with confidence.

Medication & Schedule Improvements

- **Custom Cycle Orders**: Orders using custom cycles now add correctly to the MAR without errors.
- **Hotlist Fixes**: Ended medications can now be signed off directly from the Hotlist.
- **PRN Order Start Dates**: PRNs now respect their intended start date and appear on the current-day pass as expected.
- **Bio Test Icon Accuracy**: Bio test status (red, orange, green) now updates properly in both the Hotlist and Available PRNs lists.
- **Invalid CHTS Visibility**: CHTS orders no longer show prematurely on the Med Profile before being validated and received.
- **Order Schedule Creation**: New schedules now save successfully, even when starting the next day.

Scheduling & Preview Accuracy

- **Schedule Deletion**: A prompt now requires a reason before confirming deletion, improving traceability.
- **Schedule Editing**: Fixes ensure accurate start/end dates are displayed during editing and in preview windows.
- **Preview Visibility**: Past and future scheduled doses now display correctly in the Medication Profile.

Receive Orders Reliability

- **Overlap Prevention**: Replacing orders due to mismatches or duplicates now respects user-selected start times, avoiding overlaps.

- **Validation Rules**: Users can no longer proceed without selecting valid start/end times, and warnings are shown for invalid date ranges.
- **Error Resolution**: Issues like save errors, failure to delete indications, and duplicate key exceptions during receive workflows are now resolved.
- **Detail Mismatch Handling**: Orders previously flagged as mismatches can now be received without errors.

BioTest Workflow Corrections
- **Before Tests Window**: Completed tests no longer appear again during the medication pass if already completed in the appropriate time frame.

Report & Dashboard Fixes
- **Discharge Reporting**: Residents with future discharge dates now appear correctly in Group Reports.
- **Physician Order Sheet**: Future orders now display based on community time (not UTC), ensuring more accurate reporting.
- **Supply Orders**: No longer incorrectly flagged as overdue on the dashboard.

These updates address several core areas of the EMAR system to reduce friction, prevent workflow disruption, and improve medication safety.

CRM

CRM Drop-Downs Now Support Type-to-Search
We've enhanced the CRM user experience by introducing **type-to-search functionality** in drop-down lists—making data entry faster, smoother, and more accurate.

What's Improved:
- **Faster Selection**: No more endless scrolling—just start typing to instantly filter and find what you need.
- **Wider Coverage**: Available across key CRM sections including:
  - **Contacts**
  - **Demographics**

This update helps teams save time and reduce errors during prospect intake and record updates.