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Supported New York Forms Evaluation-Based Forms

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

New York State Department of Health
Division of Assisted Living

**ASSISTED LIVING RESIDENCE
MEDICAL EVALUATION**

ALL SPACES MUST BE FILLED OUT

Resident's Name: Kimberly Harrisen **Date of Exam:** 06/12/2025

Facility Name: NY Caring Estate **Date of Birth:** _____ **Sex:** FEMALE

Present Home Address: NY Street City State Zip

Reason for evaluation: Pre-Admission 12 month Acute change in condition Other : _____

MEDICAL REVIEW FINDINGS

Vital Signs: BP: 120/80 Pulse: 99 Resp: 16 T: 98.1 Height: 6 ft _____ in. Weight: 200 _____

Primary Diagnosis(s): HTN

Secondary Diagnosis(s): Diabete

Allergies: None or list **Known Allergies:** _____

Diet: Regular No Added Salt No Concentrated Sweets Other: _____

Immunizations: Influenza (Date _____) Pneumococcal Vaccine (Date _____)

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

DSS-4449D (Rev. 4/97)

**ASSISTED LIVING PROGRAM
NURSING/FUNCTIONAL/SOCIAL ASSESSMENT**

An Assisted Living Program (ALP) provides long-term residential care, room, board, housekeeping, personal care, supervision, and provides or arranges for home health services to eligible residents in an adult care facility (ACF).

Individual's Name: Kimberly Harrisen Date of Birth: _____ SSA #: 741-51-9631

Indicate whether the individual requires assistance with any of the following. Complete all sections:

	YES	NO	DESCRIPTION/LEVEL	FREQUENCY	DURATION
Nursing		X			
Diet Counseling-		X			
Dressings	X		Dressing Change	Daily	Until healed
Vital Sign Monitoring		X			

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



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NY Caring Estate		ASSESSMENT TYPE	
		<input checked="" type="checkbox"/> Admission <input type="checkbox"/> 45 Day (Retention Standard Waiver Program) <input type="checkbox"/> 6 Month <input type="checkbox"/> Change in condition	
RESIDENT NAME		MEDICAL RECORD NUMBER	
Harrisen, Kimberly			
NAME OF PRIMARY PHYSICIAN		DATE	
		06/12/2025	
LEVEL OF FUNCTIONING		DME USED/FREQUENCY/COMMENTS	
EATING <input checked="" type="checkbox"/> 1. Independent and/or may use assistive/adaptive equipment. <input type="checkbox"/> 2. Direction/Setup and/or needs occasional help opening cartons, cutting meat, etc. <input type="checkbox"/> 3. Supervision - Needs reminders/encouragement to complete meal and occasional assist with eating. <input type="checkbox"/> 4. Assistance - Needs daily physical assistance with eating. <input type="checkbox"/> 5. Requires tube feeding and/or one to one assist with eating.			
		DME USED/FREQUENCY/COMMENTS	
DRESSING <input checked="" type="checkbox"/> 1. Independent and/or may use adaptive equipment. <input type="checkbox"/> 2. Direction/Setup and/or may need verbal cues, preparation of supplies. <input type="checkbox"/> 3. Supervision - Needs visual oversight and occasional assistance. <input type="checkbox"/> 4. Assistance - Needs daily physical assistance with dressing. <input type="checkbox"/> 5. Needs daily assistance but cleanliness and sanitation cannot be maintained.			
		DME USED/FREQUENCY/COMMENTS	
GROOMING <input checked="" type="checkbox"/> 1. Independent and/or may use adaptive equipment. <input type="checkbox"/> 2. Direction/Setup and/or may need verbal cues, preparation of supplies. <input type="checkbox"/> 3. Supervision - Needs visual oversight and occasional assistance. <input type="checkbox"/> 4. Assistance - Needs daily physical assist with grooming. <input type="checkbox"/> 5. Needs daily physical assistance but cleanliness and sanitation cannot be maintained.			
		DME USED/FREQUENCY/COMMENTS	

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

NY Caring Estate

IDENTIFYING INFORMATION	Name <u>Kimberly Harrisen</u> Maiden Name <u>Mucha</u>
	Medical Record No. <u>1234543</u> Room/Apt. No. <u>100</u> Admission Date <u>05/01/2025</u>
	Preferred Name/Title for Addressing Resident <u>Kimmy</u>
	Age _____ Date of Birth _____ Birth Place <u>Fargo</u> Citizenship <u>USA</u>
	Nationality <u>Swedish</u> Primary Language <u>ENGLISH</u> Secondary Language <u>None</u>
	Previous Address <u>1231 Sunny Street, Fargo, AK, 58081</u>
	Home Environment: Lives Alone <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Previous Living Arrangements <u>Home</u>
	Resident/Family Concerns <u>None</u>

- **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 Harrison
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) Harrison Kimberly	11A. DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT (40-60) 06 - 11 - 2025 MO DAY YEAR
4B. COUNTY OF RESIDENCE Cass	11B. DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE) (57-64) 06 - 11 - 2025 MO DAY YEAR
5. DATE OF PRI COMPLETION (18-25) 06 - 12 - 2025 MO DAY YEAR	12. MEDICAID NUMBER (65-75)
6. MEDICAL RECORD NUMBER/CASE NUMBER (26-34) 1234543	13. MEDICARE NUMBER (76-85)
7. HOSPITAL ROOM NUMBER (35-39) 123	14. PRIMARY PAYOR (86) 1 1=Medicaid 2=Medicare 3= Other
8. NAME OF HOSPITAL UNIT/DIVISION/BUILDING Sanford	15. REASON FOR PRI COMPLETION (87) 1. X RHCF Application from Hospital 2. RHCF Application from Community 3. Other (Specify:)
9. DATE OF BIRTH (40-47) - - - MO DAY YEAR	
10. SEX (48) 2 1=Male 2=Female	

Resident Demographics & Identity Forms

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

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DSS-2949 PERSONAL DATA SHEET		FACILITY NAME Peaceful Pines		ROOM NO.	
RESIDENT'S NAME (Last, First, M.I.) Alvera Fredricka		DATE OF BIRTH 06/02/1938	RELIGION Catholic	SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	SOCIAL SECURITY NO. 986-65-6326
NOTIFY IN CASE OF EMERGENCY			ATTENDING PHYSICIAN		
NAME Milly Morth			NAME John Eight		
STREET 123 Gilead Ave			STREET		
CITY West Fargo	STATE ND	ZIP CODE 58078	CITY	STATE	ZIP CODE

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

PERSONAL DATA SHEET		ADVANCED DIRECTIVES: <input type="checkbox"/> DNR <input type="checkbox"/> HCP	SEX : FEMALE	CODE Status:
FACILITY NAME Peaceful Pines		LEVEL OF CARE	ROOM NO.	
RESIDENT'S NAME (Last Name, First Name, M.I.) Fredricka Alvera	DOB: 06/02/1938	Diagnosis: Test no code, Abdominal actinomycosis, Acute and fulminating melioidosis		
RELIGION : Catholic SOCIAL SECURITY NO.: 986-65-6326	Medical Record: 5463132131321			
NOTIFY IN CASE OF EMERGENCY		ATTENDING PHYSICIAN		
NAME Milly Morth	RELATIONSHIP DAUGHTER	NAME John Eight		
STREET 123 Gilead Ave		STREET		
CITY, STATE ZIPCODE West Fargo ND 58078		CITY, STATE ZIPCODE		

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

DSS-4449B (rev.4/97)

AH EHP ALP
IDENTIFYING DATA

NAME OF FACILITY: Peaceful Pines

Name Fredricka Alvera ALP MA Start date of Care _____

Home address (prior to admission): 2528 Main Ave West Date of Birth 06/02/1938 Sex: Male Female

City West Fargo State ND Zip 58078 Social Security # 986-65-6326

Admitted From (if different from above) _____ Medicaid CIN # 12352

Street _____ Medicare # 54655453 Part A Part B

City _____ State _____ Zip _____ Other Health Insurance Co. 14

Language(s) Spoken/Understands _____ Policy Number 1236521

ENGLISH/ENGLISH Source of Income/Benefits;(Check ALL that apply)

Religion Catholic SSI Public Assistance Pension Social Ser.

Veteran's Other _____

Next of Kin/Guardian Jo Lewis

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

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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				
<input checked="" type="checkbox"/> Lab Test	<u>Glucose</u>	<u>Daily</u>	<u>RA</u>	

- **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.

The screenshot displays the 'Configuration' interface for the 'Plan of Care' section. It features three tabs: 'AREA OF FOCUS', 'EXPECTED OUTCOMES', and 'AREA OF FOCUS CATEGORY'. The 'AREA OF FOCUS' tab is active, showing a table with columns for 'Description', 'Category', and 'Status'. The table lists various activities and their associated categories and statuses. A sidebar on the right, titled 'New Area of Focus', contains a search bar, a 'New' button, and a form with fields for 'Description', 'Category', and 'Expected Outcomes'. The 'Expected Outcomes' field has a search bar and a 'none selected yet' message.

Description	Category	Status
Activities	Activities	Enabled
Activities: Independent in selection of leisure time activities	Activities	Enabled
Activities: Needs/requests assistance with management of self-directed activities (describe)	Activities	Enabled
Activities: Needs/requires occasional prompting or cueing during activities	Activities	Enabled
Activities: Needs/requires physical assist of 1 during activities	Activities	Enabled
Activities: Outside Provider assists to attend all activities	Activities	Enabled
Activities: Reminders for scheduled leisure time activities	Activities	Enabled
Alcohol Use	Alcohol Use	Enabled
Alcohol Use: Requires staff supervision when consuming alcohol.	Ambulation	Enabled
Alcoholic Beverage	Assistive Device	Enabled
Ambulation	Ambulation	Enabled
Ambulation: Independent with ambulation	Bed Mobility	Enabled

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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The screenshot shows the 'Plan of Care' configuration page with the 'EXPECTED OUTCOMES' tab selected. A table lists various outcomes, all of which are 'Long Term' and 'Enabled'. A 'New Expected Outcomes' modal is open on the right, showing a form to add a new outcome with fields for 'Description', 'Duration' (set to 'Long Term'), and an 'Enabled' toggle.

Description	Type	Status
[Res] clothes will be neat and clean	Long Term	Enabled
[Res] will be free from falls	Long Term	Enabled
[Res] will be free of s/s	Long Term	Enabled
[Res] will be independent with clothing selection and dressing	Long Term	Enabled
[Res] will receive two well balanced meals per day.	Long Term	Enabled
[Res] will walk to the dining room once a day	Long Term	Enabled
[Res] will accept assistance	Long Term	Enabled
[Res] will remain independent at meal times.	Long Term	Enabled
Activities:	Long Term	Enabled
Activities:[Res] will maintain a beneficial level of social interaction and socialization routines.	Long Term	Enabled
Activities:[Res] will maintain independence in participation of activities.	Long Term	Enabled
Activities:[Res] will participate in activities of choice.	Long Term	Enabled

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.

The screenshot shows the 'Plan of Care' configuration page with the 'AREA OF FOCUS CATEGORY' tab selected. A table lists various categories, all of which are 'Enabled'. A 'New Area of Focus Category' modal is open on the right, showing a form to add a new category with a 'Name' field and an 'Enabled' toggle.

Name	Status
Activities	Enabled
Alcohol Use	Enabled
Ambulation	Enabled
Anemia	Enabled
Anti-coagulant	Enabled
Anxiety	Enabled
Assistive Device	Enabled
Bathing	Enabled
Bed Making	Enabled
Bed Mobility	Enabled
Behavior	Enabled

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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EMAR

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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- Users are prompted to enter start and end dates.
- 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):
 - Instructions for **pharmacy-integrated medications** are read-only for all users.
 - This ensures pharmacy-supplied instructions remain accurate and unaltered.
- **When enabled:**
 - Editing instructions is allowed, but only based on existing **user permissions**.
 - 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.

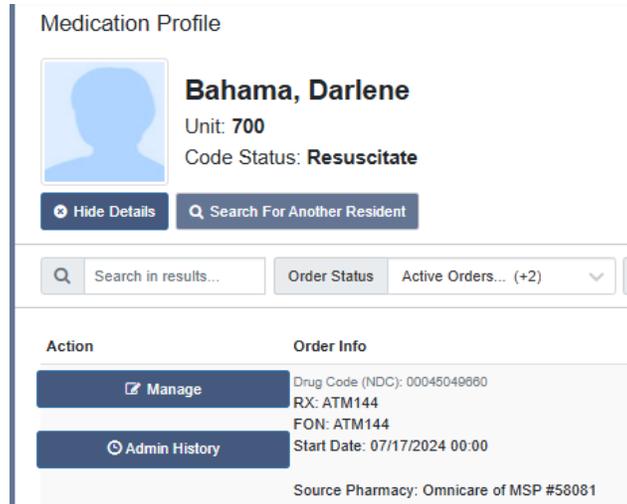
Key Features:

- **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

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- 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.

Review Schedules

Stiller, Red
Unit: 604 DOB: 08/15/1966
Code Status: Resuscitate
[Hide Details](#)

Current Active Order:
Warfarin Sodium (1 MG)
DIN: 00093171201
Rx: FON: ATM69
Route: PO
First Schedule Date: 3 Apr 2024 1700
MAR

Give 1 tablet every Tuesday and Sat
Give 2 every Thursday

Jun 2025	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed
1700	S1			S1				S1				S1						S1				S1

Last Signed Schedule: 1700 on 04/21/2024 On Hand: 0 Destroyed/Returned: 0

New Order:
Warfarin Sodium (TABLET(1 MG))
DIN: 00093171201
Rx: FON: ATM72
First Schedule Date: 3 Apr 2024 1800
MAR

Give one tablet Tuesday, Wednesday and Sunday Give 2 tablets Friday

Jun 2025	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed
1800	S1							S1				S1						S1				S1
1800							S1					S1						S1				S1
1800		S2						S2				S2						S2				S2
1800			S1						S1				S1						S1			S1

*Showing next available start time relative to the facility's current time

[Check Medication Profile](#) [Keep Both](#) [Replace Active Order](#) [Edit Order](#) [Cancel](#)

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

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

New Button Order:

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

Review Schedules

BREWER, PENELOPE
Unit: 05 DOB:06/22/1957
Code Status: Resuscitate

Current Active Order :
ALBUTEROL SUL 2.5 MG/3 ML ML
SOLN(3 ML) DIN : 00378827052
Rx : 1219115
FON : 0800003109704673
First Schedule Date: 2 Jul 2024
0000

INHALE 0.5CC EVERY 6 HOURS WITH IPRATROPIUM VIA NEBULIZER

Jun 2025	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed
← Jul 2025 →	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	01	02	03	04	05	06	07	08	09
1800	S0.5																												
1200	S0.5																												
0600	S0.5																												
0000	S0.5																												

New Order :
ALBUTEROL SUL 2.5 MG/3 ML NEBU
SOLN(3 ML) DIN : 00378827052
Rx : 1219115
FON : 0800003109704673
First Schedule Date: 2 Jul 2024
0000

INHALE 0.5CC EVERY 6 HOURS WITH IPRATROPIUM VIA NEBULIZER

Jun 2025	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed
← Jul 2025 →	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	01	02	03	04	05	06	07	08	09
1200	S0																												
1800	S0																												
0000	S0																												

*Showing next available start time relative to the facility's current time

Check Medication Profile Accept Update Edit Order Reject Update 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.

NEXT Release Notes

- 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.



NEXT Release Notes

- **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.

