



# Adding Resident

Select the “Add New Resident” link. This will take you to the “Name and E-Mail form.”



**Step 1.** Fill out the Name and Email form required fields. Required fields are marked with an asterisk \*

**Add New Resident**

**NAME AND E-MAIL -- Step 1**

**\* Required**

First Name \*

Preferred First Name

Middle Name

Last Name \*

Name Suffix

Email

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**PHOTO**

Photo taken  Signature

Photo  [Document Library](#)

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**CHANGE UNIT**

Change Unit

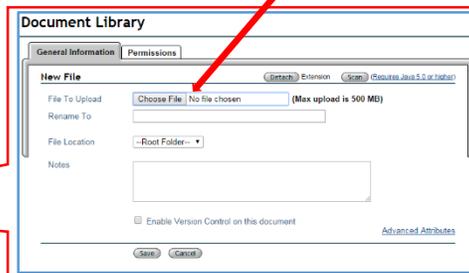
Provider Users Relationship

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**\* Required**

Attach a photo by selecting the edit pencil and then choose a file from your computer. (This photo will need to have been previously downloaded)

Step 1 of 3



Advance to the next step by clicking the “next” button

**Step 2.** Fill out the Resident Info form.

Step 2 of 3

**Add New Resident**

**RESIDENT INFO -- Step 2**

**\* Required**

Date \*

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**BASIC INFORMATION**

Resident Type \*

Med Group Default

ADL Group No options available. There are no entries which meet the criteria specified.

Gender

Birth Date

Age

Social Security Number

Medical Record Number

Other Record Number

Pharmacy Patient Id

Languages Spoken

English  Italian  Russian

Spanish  Japanese  Hebrew

French  Chinese  Greek

German  Portuguese  Other

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**PREFERENCES**

Religious Preference

Clergy

Phone

Home Care Agency

Phone

Hospice Agency

Phone

Hospital Preference

Phone:

Mortuary

Phone

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**ADVANCED INFORMATION**

Date field is NOT admission date. This is the date when the form is completed.

Age is automatically generated from Birth Date.

**Step 3.** Check one of the options below. Admission, Re-Admission or Pending Resident. Once this form is saved, the resident will either be an active resident or a pending resident.

### Add New Resident

ADMISSIONS/RE-ADMISSION -- Step 3

Date/Time

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**\* Required**

Date/Time

Admission Type  Admission  Re-Admission  Pending Resident

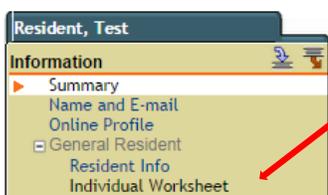
[Update all fields with current admission/readmission data](#)

Room/Bed #: Record does not meet the requirements of the relationship.

Dining room seat:

Step 3 of 3

**Optional Step 4.** *Individual Worksheet* optional forms can now be filled out to complete the admission or fill in other data. These optional forms are located on the resident left navigation menu.



### Individual Worksheet

**\* Required**

Resident, Test

Code status: [no data]  
Age: [no data]  
Date of birth: [no data]  
Gender: Female  
Spouse: [no data]  
Status: [no data]  
Chart #: [no data]

Date \*

Room/Bed #

Security Code

Move-In/Admit Date \*

Arrival Meeting date

Meeting Set  Resident and/or family notified of meeting

**Code Status**  Do NOT Resuscitate (DNR)  Resuscitate

Invoice Layout Default  Simple  Expanded  Full

**MEDICAL DOCUMENTATION**

**ASSIGNMENT DETAILS**

Entered by:  Staff signature

**MOVE-IN FINANCIAL CALCULATOR**

**\* Required**

Only available rooms will be displayed. If a room doesn't appear in this drop down it is likely because it is set as a single occupied room (see community set-up) or it is held/occupied by another resident.

Medical Documentation can be uploaded by expanding the Medical Documentation section.

**MEDICAL DOCUMENTATION**

Document Type

Advance Directive  Is complete and on file

AD Dated

AD link  [Document Library](#)

No file selected.

Document Type

Advance Directive  Is complete and on file

AD Dated

AD link  [Document Library](#)

No file selected.

Document Type

Advance Directive  Is complete and on file

AD Dated

AD link  [Document Library](#)

No file selected.

Document Type

Advance Directive  Is complete and on file

AD Dated

AD link  [Document Library](#)

No file selected.

Entry documentation received  
Guardianship, commitment,  
etc.  
Documentation link  Staff signature

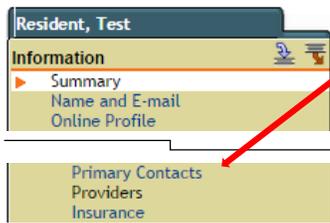
No file selected. [Document Library](#)

Physician communication form  
Physician communication link  Is complete and on file

No file selected. [Document Library](#)

Medical emergency alarm  Installed

## Optional Step 5. Primary Contacts



The contact order field lists the contact in order of preference. This order is displayed on the Residents record summary.

The 'Primary Contacts' form is shown for Jane Doe. A red arrow points to the 'Contact Order' field, which is set to 1. The form includes fields for Date, Full Name, Relationship to Resident, Type of Contact, and various phone numbers and addresses.

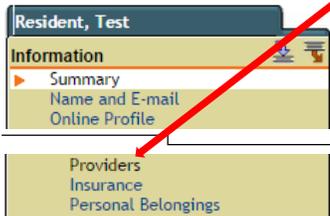
- 
- Self
  - Son
  - Daughter
  - Grandson
  - Granddaughter
  - Son-in-law
  - Daughter-in-law
  - Sister
  - Brother
  - Husband
  - Wife
  - Father
  - Mother
  - Cousin
  - Other

Multiple contacts are added by clicking the new entry button. All contacts information will be displayed as shown below.

The 'Primary Contacts' record summary shows a table of contacts and a 'New Entry' button. The table lists the contact order, full name, home phone, cell phone, work phone, relationship to resident, and type of contact.

Contact Order	Full Name	Home Phone	Cell Phone	Work Phone	Relationship to Resident	Type of Contact	Edit Delete
1	Jane Doe	(801) 555-1212	(801) 222-5454		Daughter	Emergency contact, Financially responsible party	

## Optional Step 6. Providers



Select a provider from the drop down list. Providers are added through the “add provider” link. (See Adding Providers)

Once a provider is selected, define the provider’s roll.

**Providers**

**\* Required**

Resident, Test

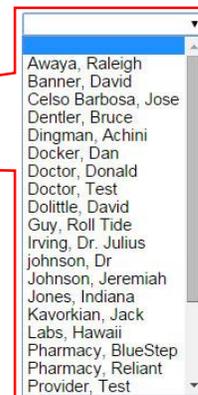
Code status: [no data]  
Age: [no data]  
Date of birth: [no data]  
Gender: Female  
Spouse: [no data]  
Status: [no data]  
Chart #: [no data]

Provider: \* Test, Dr

Role:

- Admitting physician
- Attending physician
- Audiologist
- Cardiologist
- Chiropractor
- Dentist
- Dermatologist
- Neurologist
- Nurse Practitioner
- Optometrist/Ophthalmologist
- Orthopedic
- Pharmacy
- Physical therapist
- Physician or Specialist
- Physician's Assistant
- Podiatrist
- Primary care MD
- Urologist

**\* Required** Save Cancel



Multiple providers are added by clicking the new entry button. All providers information will be displayed as shown below.

**Providers** New Entry

Resident, Test

Code status: [no data]      Current date: 09/15/2014  
Age: [no data]      Primary care physician: Test, Dr  
Date of birth: [no data]      Physician phone: (801) 860-3059 Fax: [no data]  
Gender: Female      Room #: Demo Unit--102 (No Photo)  
Spouse: [no data]      Location: [no data]  
Status: [no data]      Facility: Demo Unit  
Chart #: [no data]      Admission: 10/03/2011 12:00PM

Provider	Role	Provider Information	Edit Delete
Test, Dr	Primary care MD	E-mail: [no data] Layton, UT 84041 Phone: (801) 860-3059 Fax: [no data]	

## Optional Step 7. Insurance

Resident, Test

Information

- Summary
- Name and E-mail
- Online Profile

Providers

- Insurance
- Personal Belongings

This form provides fields to input Primary, Secondary, and RX insurance.

Insurance information is also displayed on the Resident Record Summary.

**Insurance**

**\* Required**

Resident, Test

Code status: [no data]  
Age: [no data]  
Date of birth: [no data]  
Gender: **Female**  
Spouse: [no data]  
Status: [no data]  
Chart #: [no data]

Date: \* 01/28/2011

Subscriber Full Name: \_\_\_\_\_  
Subscriber Social Security #: \_\_\_\_\_  
Medicare #: \_\_\_\_\_  
Medicaid #: \_\_\_\_\_  
Medicare/Medicaid link: No file selected. [Document Library](#)

Employer: \_\_\_\_\_  
Eligible for VA benefits?  No  Yes  
Name of Rep Payee: \_\_\_\_\_  
BES Worker: \_\_\_\_\_

**PRIMARY INSURANCE**

Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Phone 2: \_\_\_\_\_  
Policy/Identification Number: \_\_\_\_\_  
Subscriber/Group #: \_\_\_\_\_  
Insurance card link: No file selected. [Document Library](#)  
Coverage ID: \_\_\_\_\_  
Insurance Effective Date: \_\_\_\_\_  
Insurance Notes: \_\_\_\_\_

Continue form ...

**ADDITIONAL INSURANCE**

Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Phone 2: \_\_\_\_\_  
Policy/Identification Number: \_\_\_\_\_  
Subscriber/Group #: \_\_\_\_\_  
Insurance card link: No file selected. [Document Library](#)  
Coverage ID: \_\_\_\_\_  
Insurance Effective Date: \_\_\_\_\_  
Insurance Notes: \_\_\_\_\_

**PRESCRIPTION INSURANCE**

Prescription Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Phone 2: \_\_\_\_\_  
Policy/Identification Number: \_\_\_\_\_  
Subscriber/Group Number: \_\_\_\_\_  
Bin #: \_\_\_\_\_  
Prescription card link: No file selected. [Document Library](#)  
Prescription Effective Date: \_\_\_\_\_  
Status: \_\_\_\_\_  
Prescription Notes: \_\_\_\_\_

**VERIFICATION OF BENEFITS**

## Optional Step 8. Medication Prescribed: Entering in a new medication order.

Resident, Test

Information

- Summary
- Name and E-mail
- Online Profile

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Medications

- Medication - Prescribed
- Medication Prompts

When the Medication – Prescribed link is selected a list of previously entered Meds are listed as seen below. To enter a new medication order, click on the new entry button.

**Medication - Prescribed** Print

Resident, Test

Code status: [no data]      Current date: 09/15/2014  
 Age: [no data]      Primary care physician: Test, Dr  
 Date of birth: [no data]      Physician phone: (801) 860-3059 Fax: [no data]  
 Gender: Female      Room #: Demo Unit→102  
 Spouse: [no data]      Location: [no data] (No Photo)  
 Status: [no data]      Facility: Demo Unit  
 Chart #: [no data]      Admission: 10/03/2011 12:00PM

New Entry

**ACTIVE MEDICATIONS**

Medication	Med Class	Prescribed by	Physician's Instructions	Schedule	Start Date	Order fill/refill	Edit Delete
Acetaminophen Caplets (C2)	C2	Provider, Test	Take	(500 mg) 7:30am, 11:30am, 4:30pm, 9:00pm	08/29/2014		
AndroGel Packets every wed	C3 or C4	Provider, Test	Test	(TEST) AM, PRN (25mg) PRN every 21 days	02/13/2014	Trevor Fuhrman, 07/02/2014 1:46:47PM	

PENDING MEDICATIONS

MEDICATIONS AWAITING APPROVAL

DISCONTINUED MEDICATIONS

Done

**MEDICATION INFORMATION**

Medication \* Lortab 10/325

Drug Dosage Form \* Tablet

Medication Classification \* C2  C3 or C4  C5  Standard

Diagnosis \* Pain

Route of Administration \* 01 Oral (PO)

Vital Signs Required  vital signs must be taken with this medication

Assistance needed \*  Self-Administer  Reminder to take  Open container  Significant (Total)  
 Self-Directed  Family/Designated Person  Refill reminder

Physician's Instructions \* Take 1 tab as needed for Pain

Vital Signs Required        vital signs must be taken with this medication  
 Vitals Required  Blood Pressure  Temperature  Respiratory Rate  
 Heart Rate  Glucose/Blood Sugar  Weight

If vitals are required to be given with this medication, select the "Vital Signs Required" check box. This will allow you to attach one or more vitals that will be required to be recorded when administering this medication.

**MAR SCHEDULING**

Dosage \* 1

Scheduling Options \*  Daily or PRN  Every (Interval) days  Specific days of the week  Specific days of the month

Start Date \* 09/15/2014

Number of Days - OR - End Date

Scheduled Time(s) \*  AM  12:00am  4:30am  9:00am  1:30pm  6:00pm  10:30pm  
 Breakfast  12:30am  5:00am  9:30am  2:00pm  6:30pm  11:00pm  
 Morning  1:00am  5:30am  10:00am  2:30pm  7:00pm  11:30pm  
 PM  1:30am  6:00am  10:30am  3:00pm  7:30pm  PRN  
 Lunch  2:00am  6:30am  11:00am  3:30pm  8:00pm  
 Afternoon  2:30am  7:00am  11:30am  4:00pm  8:30pm  
 Dinner  3:00am  7:30am  12:00pm  4:30pm  9:00pm  
 Bedtime  3:30am  8:00am  12:30pm  5:00pm  9:30pm  
 Graveyard  4:00am  8:30am  1:00pm  5:30pm  10:00pm

PRN Follow-up  30 minutes

PRN Interval 4.0

MAR Instructions \* Administer 1 Oral (PO) as needed no more than once per 4 hours. Follow up after 30 minutes

Done Void

Dosage Date(s) Schedule Instructions Created Edit Void

Adding Timing... Additional Timing

Med Group Cart 2

When scheduling a medication you have several options. Select the desired option

Select a general or specific time.

If a PRN is selected, define the PRN Follow time (how long until you want to be alerted for a follow up) and the PRN interval (How long between each administration)

**MAR SCHEDULING**

Dosage \* 1

Scheduling Options \*  Daily or PRN  Every (Interval) days  Specific days of the week  Specific days of the month

Start Date \* 09/15/2014

End Date

Interval (Days) \* 2

Scheduled Time(s) \*  AM  12:00am  4:30am  9:00am  1:30pm  6:00pm  10:30pm  
 Breakfast  12:30am  5:00am  9:30am  2:00pm  6:30pm  11:00pm  
 Morning  1:00am  5:30am  10:00am  2:30pm  7:00pm  11:30pm  
 PM  1:30am  6:00am  10:30am  3:00pm  7:30pm  PRN  
 Lunch  2:00am  6:30am  11:00am  3:30pm  8:00pm  
 Afternoon  2:30am  7:00am  11:30am  4:00pm  8:30pm  
 Dinner  3:00am  7:30am  12:00pm  4:30pm  9:00pm  
 Bedtime  3:30am  8:00am  12:30pm  5:00pm  9:30pm  
 Graveyard  4:00am  8:30am  1:00pm  5:30pm  10:00pm

PRN Follow-up 30 minutes

PRN Interval 4.0

MAR Instructions \* Administer 1 Oral (PO) as needed no more than once per 4 hours. Follow up after 30 minutes.

Additional Timing

Med Group Cart 2

If the Scheduling option “Every (Interval) Days” is selected, you will need to define the Start Date and the Interval (Days).

Interval (Days) on this example, will display this medication every 2 days from the start date. If this medication needed to be displayed every 3<sup>rd</sup> day, then this field would need to have a “3” entered.

**MAR SCHEDULING**

Dosage \* 1

Scheduling Options \*  Daily or PRN  Every (Interval) days  Specific days of the week  Specific days of the month

Start Date \* 09/15/2014

End Date

Days of the Week \*  Su  M  Tu  W  Th  F  Sa

Scheduled Time(s) \*  AM  12:00am  4:30am  9:00am  1:30pm  6:00pm  10:30pm  
 Breakfast  12:30am  5:00am  9:30am  2:00pm  6:30pm  11:00pm  
 Morning  1:00am  5:30am  10:00am  2:30pm  7:00pm  11:30pm  
 PM  1:30am  6:00am  10:30am  3:00pm  7:30pm  PRN  
 Lunch  2:00am  6:30am  11:00am  3:30pm  8:00pm  
 Afternoon  2:30am  7:00am  11:30am  4:00pm  8:30pm  
 Dinner  3:00am  7:30am  12:00pm  4:30pm  9:00pm  
 Bedtime  3:30am  8:00am  12:30pm  5:00pm  9:30pm  
 Graveyard  4:00am  8:30am  1:00pm  5:30pm  10:00pm

PRN Follow-up 30 minutes

PRN Interval 4.0

MAR Instructions \* Administer 1 Oral (PO) as needed no more than once per 4 hours. Follow up after 30 minutes.

Additional Timing

Med Group Cart 2

If the Scheduling option “Specific days of the week” is selected, you will need to define the Start Date and the Specific Days of the Week.

The Additional Timing button allows you to add an addition Schedule to this medication order. If for example this same medication needed to be given on the opposite days of the week with a different dosage, you can simply add an additional timing rather than adding a completely new order.

**MAR SCHEDULING**

Dosage \* 1

Scheduling Options \*  Daily or PRN  Every (Interval) days  Specific days of the week  Specific days of the month

Start Date \* 09/15/2014

End Date

Days of the Month \*  1  3  5  7  9  11  13  15  17  19  21  23  25  27  
 2  4  6  8  10  12  14  16  18  20  22  24  26  28

Scheduled Time(s) \*  AM  12:00am  4:30am  9:00am  1:30pm  6:00pm  10:30pm  
 Breakfast  12:30am  5:00am  9:30am  2:00pm  6:30pm  11:00pm  
 Morning  1:00am  5:30am  10:00am  2:30pm  7:00pm  11:30pm  
 PM  1:30am  6:00am  10:30am  3:00pm  7:30pm  PRN  
 Lunch  2:00am  6:30am  11:00am  3:30pm  8:00pm  
 Afternoon  2:30am  7:00am  11:30am  4:00pm  8:30pm  
 Dinner  3:00am  7:30am  12:00pm  4:30pm  9:00pm  
 Bedtime  3:30am  8:00am  12:30pm  5:00pm  9:30pm  
 Graveyard  4:00am  8:30am  1:00pm  5:30pm  10:00pm

PRN Follow-up 30 minutes

PRN Interval 4.0

MAR Instructions \* Administer 1 Oral (PO) as needed no more than once per 4 hours. Follow up after 30 minutes.

Additional Timing

Med Group Cart 2

If the Scheduling option “Specific days of the month” is selected you will need to define the specific day(s) of the month you would like this medication to appear on the MAR. Note that there are no days from the 29<sup>th</sup> – 31<sup>st</sup>. Since this schedule is recurring every month, there are some months that don’t have these days available.

Select the Doctor this order was prescribed by and check the Data entered by check box. You may also check the Nursing/Admin. Review box if you are a nurse. Click the Save button to complete this order.

**AUTHORIZATIONS**

Prescription must be authorized prior to ordering

Prescribed By \*

Add New Prescriber

Data entered by \*  I certify this information complete and correct  
 I certify this information complete and correct

Nursing/Administrator Review

ONE-Click Messages Relationship [no data]

\* Required

## Optional Step 9. Medication Prompt

Resident, Test

Information

- Summary
- Name and E-mail
- Online Profile

Medications

- Medication - Prescribed
- Medication Prompts

**Medication Prompts**

Resident, Test

Code status: [no data]  
Age: [no data]  
Date of birth: [no data]  
Gender: Female  
Spouse: [no data]  
Status: [no data]  
Chart #: [no data]

Standard Prompts

- Crush medications before administering
- Mix medications with food
- Take blood pressure before administering meds
- Take glucose (blood sugar) level before administering meds
- Take O2 saturation level before administering meds
- Take weight before administering meds
- Hold medications

**MEDICATION CONTRAINDICATIONS**

Enter medications (at the direction of physician or pharmacy) that interact with currently prescribed medication

Contraindicated drugs  Select  
Enter medications

Drug allergies  Select  
Allergies tylenol

**CUSTOM PROMPTS**

Custom Prompt  Select  
Enter text My Custom Prompt

Custom Prompt  Select  
Enter text

Custom Prompt  Select  
Enter text

Custom Prompt  Select  
Enter text

Medication Prompts allow you to post instructions to staff that are passing medications.

A standard prompt can be selected or a custom prompt can be created

Resident, Test

Code status: [no data]  
Age: [no data]  
Date of birth: [no data]  
Gender: Female  
Spouse: [no data]  
Status: [no data]  
Chart #: [no data]

Current date:  
Primary care physician:  
Physician phone:  
Room #:  
Location:  
Facility:  
Admission:

**My Custom Prompt**  
**DO NOT ADMINISTER tylenol**

**Medications to be Administered Today, Monday 10/06/2014**

Medication MAR Detail

Sched Admin Time: AM

AndroGel Packets

Staff signature

Dosage: TEST \*      Diagnosis: Test

Exception:      Notes:

When the Med Prompt is saved the staff will see the prompt message appear above the resident's medications as they prepare to administer/pass the medications

## Optional Step 10. Medical History

Resident, Test

Information

- Summary
- Name and E-mail
- Online Profile

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Medical

- Doctors' Orders
- Medical History

### Medical History

\* Required

Resident, Test

Code status: [no data]  
 Age: [no data]  
 Date of birth: [no data]  
 Gender: Female  
 Spouse: [no data]  
 Status: [no data]  
 Chart #: [no data]

Date \* 05/06/2013

Current Diagnosis

#### REVIEW OF HEALTH HISTORY

Please check all that apply

Medical Conditions  
 Check any that the resident currently has or has had.

<input type="checkbox"/> Anaphylactic Shock	<input type="checkbox"/> Hives/skin allergies
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Kidney disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Knee or ankle injuries
<input type="checkbox"/> Back injury	<input type="checkbox"/> Long Measles
<input type="checkbox"/> Bladder/kidney infection	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Bone condition/broken bone	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Bowel problem	<input type="checkbox"/> Mumps
<input type="checkbox"/> Cancer	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Polio
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Positive TB test
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Fainting/dizziness	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Frequent colds/Sore throat	<input type="checkbox"/> Seizure
<input type="checkbox"/> Frequent constipation/Diarrhea	<input type="checkbox"/> Serious injury
<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Three-day Measles
<input type="checkbox"/> Hayfever	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Heart troubles/disease	<input type="checkbox"/> Tuberculosis
<input checked="" type="checkbox"/> Hepatitis	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Other
<input type="checkbox"/> High cholesterol/fats	<input type="checkbox"/> None
<input type="checkbox"/> HIV Positive/AIDS	

Select any of the medical conditions that apply. If none of the conditions apply either select the "other" check box or the "none" check box.

Explain all checked above  
 Used on state report. Please include dates.

#### PREVIOUS EXAM RESULTS

Last Exam Date

Blood Type

Current Weight

Surgeries

Pacemaker?  
 List all medical devices in use

Drug Allergies

Allergies  
 List foods and other substances allergies

Describe any special needs  
 Especially related to religion, nationality, race or sexual orientation

The Drug Allergies text field will display all drug allergies on the resident record summary and also on the medication prompt form.

The Allergies text field will display all food allergies or other allergies on the resident record summary.

Completed by: Kristine Squire

\* Required

Save Save and Refresh Cancel