



Veridence Feature List

COMPLIANCE SUITE • EMAR SUITE • FULL EHR

Three editions, each built on the one before. The eMAR Suite includes everything in the Compliance Suite, and the Full EHR includes everything in the eMAR Suite.

Compliance Suite

Keep your EHR. Veridence reads it and does the compliance work.

FEATURE	WHAT IT DOES	FEATURE	WHAT IT DOES
SURVEY READINESS			
Mock survey	What a surveyor would cite	F-tag coverage register	All 202 federal tags
CMS-802 resident matrix	Filled from the record	Survey day pack	Entrance documents ready
Chart check	Citations, resident by resident	Survey readiness intelligence	Root causes, ranked
Risk-based survey qualification	Shorter survey eligibility	Administrator daily brief	Priorities every morning
Critical events	What needs the DON	Building handover	Last 12 months summarized
Chart completeness audit	Missing documentation found	Note and record contradictions	Conflicting entries flagged
Record integrity	Tamper-evident record seal	Integrity attestation	Evidence for QAPI
QUALITY AND FIVE-STAR			
CMS quality measures	Per resident, from MDS	Five-Star position	Rating drivers tracked
Value-based purchasing position	The 2% withhold, in-year	CoreQ satisfaction	Residents and families scored
Early-warning trends	Declines caught early	Alert prioritization	Escalation by urgency
Impact summary	Value delivered, measured		
MEDICATION OVERSIGHT			
Medication compliance	Late, missed, refused doses	PRN effectiveness	Follow-up documented
Medication errors	Likely MAR errors flagged	Controlled substance diversion risk	Diversion patterns surfaced
DEA biennial inventory	Controlled counts ready	Drug labeling and storage	Controlled substance integrity
Pharmacy services and records	Drug record checks	Drug regimen review	Pharmacist findings tracked
Psychotropic stewardship	Dose reductions tracked	Opioids and MME	Daily dose, benzodiazepines
Medication use review	Burden, overlaps, restarts	Polypharmacy risk	High medication counts
Medication interactions	Interactions flagged	Medication reconciliation	Transitions reconciled
Insulin and glucose pairing	Doses matched to readings	Medication order changes	Who changed what
Medications with no times	Unscheduled orders found	Medication risk index	Risk by resident
Smart refill prediction	Refills before runout	Daily refill requests	Refills due today
Emergency downtime MAR	Printable backup record		
CLINICAL RISK			
Falls and accidents	Falls, follow-up, hazards	Pressure injuries	Wounds tracked to healing
Pain management	Reassessment documented	Continence and UTI	Infections and continence
Infection control and antibiotics	Antibiotic use reviewed	Infection surveillance line list	Every case tracked

Infection preventionist activity	IP work documented
Change in condition watch	Unassessed changes flagged
Labs ordered, not resulted	Missing results found
Trauma-informed care	Screened and care planned
Hospice coordination	Agreement and shared plan
Care ordered and delivered	Gaps between them
Care plan timing	Baseline, comprehensive, IDT
Physician visits	Due and overdue
Shift note completeness	Missing notes found

MDS AND ASSESSMENTS

MDS assessment tracking	Due, late, transmitted
MDS coding accuracy	Codes supported by chart
Significant change support	When to reassess
PDPM capture review	Accurate PDPM coding
Assessment items needing response	Open items listed

RESIDENTS AND EVENTS

Incident and accident reports	Logged and investigated
Abuse and neglect reporting clock	Deadlines never missed
Room changes and leaves	Notice before moves
Discharges in progress	Discharge worklist
Resident directory	Profiles with photos
Admissions desk	Referrals and decisions

STAFFING

Staffing hours per resident day	HPRD by shift
Staffing recommendation	Acuity-weighted levels
Staff credentials	Expirations flagged early
In-service hours	Aide training hours
Staff performance analytics	Team trends
Exclusion screening	OIG list checks

FACILITY COMPLIANCE

Life safety log	Drills and inspections
Policy library	Versioned, signed policies
Compliance program	Training, concerns, screening
Supply inventory	Stock on hand

DATA, ACCESS AND REPORTING

EHR data import	Your export, read only
Report library	More than 100 reports
12-month look back	Plus 6 and 3 months
Role-based access	Each role sees own

Immunizations	Vaccines offered, documented
Critical lab results	Results needing action
Behavior monitoring	Psychotropic purpose documented
Nutrition and weight	Weight loss, meals, diets
Dialysis communication	Every session, both ways
Care plan and documentation	Plan matches charting
Resident risk flagging	High-risk residents surfaced
Decision-maker gaps	Missing representatives found

MDS timeliness	Late or missing assessments
MDS coding-risk flags	Risky codes flagged
Case-mix distribution audit	Coding drift detected
Assessments due	Upcoming assessments listed
PASARR tracking	Screening and follow-up

Grievance log	Written decisions tracked
Admission packet review	Signed, declined, missing
Activities and social services	Participation tracked
Document management	Directives and consents
Bed board	Beds and occupancy
Coverage horizon	Who runs out, when

Daily staffing posting	Posted nurse staffing
Staffing and med pass timing	Staffing effect measured
Staff competency	Competencies tracked
Agency and overtime warning	Weekly cost alerts
Workflow bottlenecks	Delays found

Emergency preparedness	Plan and evacuation roster
Facility assessment	Required assessment completed
Resident council	Concerns to resolution
Assisted living state rules	State requirements mapped

Read-only by design	Nothing written back
One click to evidence	Every number drills down
Phone app for leadership	Live view and alerts
Complete audit trail	Every action attributed

FINANCIAL

Triple Check	Month end, from record
Medicare Advantage authorizations	Concurrent review ready
Coverage ledger	Who pays, how long
Physician certification	Dates and signatures
Medicare payment setup	Wage index configured

ADD-ON: WORKFORCE

Open shifts and swaps	Filled by staff
PBJ staffing file	Ready for CMS

ADD-ON: AI ASSISTANT

AI assistant	Answers from the record
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ADD-ON: HOSPITALS AND NHSN

Hospital admit and discharge notices	Matched to residents
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ADD-ON: ENTERPRISE

Group view	Every building, one screen
Single sign-on	One login, every building

Audit defense	ADR, TPE, RAC, UPIC
Claim integrity	Payer rules checked
Billing readiness	Gaps before billing
Therapy documentation	Rehab log checked
Medicare Advantage appeals	Appeal packet from the chart

Agency requests	Tracked and approved
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Cited resident summary	Sources on every line
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NHSN weekly report	Pathogens and vaccination
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Group benchmarking	Buildings ranked side by side
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eMAR Suite

Everything in the Compliance Suite, plus the eMAR and clinical record.

FEATURE	WHAT IT DOES	FEATURE	WHAT IT DOES
MEDICATION ADMINISTRATION			
Bedside eMAR	Doses charted when given	Barcode scanning	Right resident, right drug
Wristband scan to identify	Camera confirms resident	Med pass from orders	Built automatically
Med pass control and setup	Pass managed by unit	Live med pass board	Progress in real time
Admin live feed	Pass as it happens	Med pass daily overview	Sequence by unit
Med pass reports	Daily pass record	Monthly MAR	Printable monthly record
PRN follow-up	Reassessed on time	PRN escalation	Ineffective doses alerted
Psychotropic PRN renewals	14-day renewal alerts	Voided administrations	Every void explained
Downtime recovery	Paper doses entered back		
CONTROLLED SUBSTANCES AND PHARMACY			
Controlled substance counts	Counts, waste, signatures	Tamper-evident narcotic record	Changes cannot hide
Pharmacy orders	Sent electronically	Pharmacy refills	Requested automatically
Pharmacy dispense feed	Dispenses recorded	Consultant pharmacist review	Findings to prescriber
ORDERS			
Order entry with safety checks	Allergies, interactions checked	Order sets	Standard orders, signed
Prescriber electronic signing	Physician signs electronically	Order and signing separated	Nurse enters, prescriber signs
Signing queue	Orders awaiting signature	Partner orders held	Signed before use
CLINICAL CHARTING			
Vitals and observations	Charted at bedside	ADLs	Daily care documented
Care plans	Built and reviewed	Wound care and skin	Measured, PUSH scored
Treatment record (eTAR)	Treatments documented	Change in condition (SBAR)	Assessed and notified
Care cards	Daily care at glance	Enhanced barrier precautions	Devices and wounds tracked
Nutrition, meals and weights	Intake and diet orders	Meal tickets	Diet order on tray
Clinical notes	Shift and progress notes	Resident chart	System of record
MDS			
MDS coding	Validated before submission	iQIES submission file	Built automatically
CMS edits	Errors caught early	Section GG prefill	Proposed from chart
Care area triggers	CAAs from MDS	Corrections and inactivations	Handled by rule
ON THE FLOOR			
Phone app for nurses and aides	Chart from anywhere	Phone app for physicians	Orders signed anywhere
Read and write by account	Limits set per user		
FINANCIAL, THE FULL SUITE, ADDS TO THE ABOVE			
Eligibility checks	Coverage verified with payer	Claims from the record	Institutional claims built
Claim tracker	Every claim followed	Payment posting	Remittances read and matched
Denials	Payer reasons listed	Prior authorization	Requests and answers
Expected payment	What each day pays	Remittance and variance	Underpayments found
Overpayment obligations	60-day clock tracked	Money held up	Every dollar explained

Missed charges	Care never charged
Contribution margin by payer	Value of each day
Operating ledger	Cost per resident day
Resident trust	Residents' funds protected
General ledger	Drafted, person posts
Bank reconciliation	Statements matched monthly
Paid time off	Earned and tracked

FAMILY AND SPANISH

Family portal	Secure family access
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Payer scorecard	Plans ranked by behavior
Labor cost and agency premium	What hours cost
Resident accounts	Charges and statements
Family statement and estimate	One bill, honest estimate
Bills to pay	Two-person approval
Payroll preparation	Hours ready for payroll
1099s and year-end close	Year closed cleanly

Spanish screens	Kiosk and aide screens
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Full EHR

Everything in the eMAR Suite, plus the complete clinical record.

FEATURE	WHAT IT DOES	FEATURE	WHAT IT DOES
CLINICAL RECORD			
Admission packet with e-signature	Signed and stored	Lab orders to laboratory	Sent, closed by result
Hospital transfer packet	Complete, also C-CDA	Room moves and leaves	Moves with notice
Activities and social services	Sessions and notes charted	Aide shift board	ADLs, meals, weights owed
Charting kiosk	Quick sign-in charting		
RECORDS IN AND OUT			
Hospital records in	Reviewed before charting	Lab results in	Filed to the order
Health information exchange	Standard formats supported	Outbox with acknowledgment	Every send confirmed
Partner keys	Secure, limited access		
WORKFORCE, INCLUDED			
Staff schedule builder	Schedule against time clock	Open shifts and swaps	Filled by staff
Agency requests	Tracked and approved	PBJ staffing file	Ready for CMS
ALSO INCLUDED			
AI assistant	Answers from the record	Cited resident summary	Sources on every line
Hospital admit and discharge notices	Matched to residents	NHSN weekly report	Pathogens and vaccination

Veridence is decision support. It is not legal, clinical or regulatory advice. Findings are to be reviewed by qualified personnel, and clinical and compliance decisions remain with the facility.

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