HCA/DDSD REQUIREMENTS for Medically Fragile Waiver: Nursing Lic and Training File Review – SURVEY TOOL

AGENCY / REGION: | | **DATE OF SURVEY:** | |
SURVEYOR: | |

Surveyor Instructions:

NMAC 7.28.2.23 – Licensure/Certification Requirements (Tag # MF23): *Nurses must be licensed Register Nurses (RN) or Licensed Practical Nurses (LPN) in the state of New Mexico with a current licensure as defined by the New Mexico Board of Nursing (NM BON). If necessary, the surveyor may verify this on the NM BON Nursing website. For this to be met, there must be evidence of current licenses for nurse personnel on file with the agency.*

NMAC 7.1.14.9 – Incident Management System Requirements (Tag # 1A28.1): *All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures require all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. For this to be met, there must be evidence that training occurred for required agency personnel.*

					MET	NOT MET
Agency Personnel	**Title / Position Held**	**Date of Hire**	**Licensure # / Expiration Date**	**Annually ANE Training**	*Surveyors: Document met or not met and any additional notes specific to staff reviewed after reconciliation is complete. Any area deficient must be circled.*	
Notes:						
Notes:						
Notes:						
Notes:						
Notes:						

Agency Representative Name/Signature, Title & Date Received: _____

Training Evidence Must be provided to Survey Team by: **DATE:** _____ **TIME:** _____

Original copy to Survey Team Lead & Copy to Provider Representative

					MET	NOT MET
Agency Personnel	**Title / Position Held**	**Date of Hire**	**Licensure # / Expiration Date**	**Annually ANE Training**	*Surveyors: Document met or not met and any additional notes specific to staff reviewed.*	
Notes:						
Notes:						
Notes:						
Notes:						
Notes:						
Notes:						
Notes:						
Notes:						
Notes:						

Agency Representative Name/Signature, Title & Date Received: _____

Training Evidence Must be provided to Survey Team by: **DATE:** _____ **TIME:** _____

Original copy to Survey Team Lead & Copy to Provider Representative