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	0013710	A. BUILDING: _____ B. WING _____	R-C 02/05/2024

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K & D AFH LLC 3	3709 10TH AVE RACINE, WI 53402

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{M 000}	INITIAL COMMENTS On 02/01/2024, with information gathered through 02/05/2024, Surveyor conducted a standard survey, verification visit, and complaint investigation. As a result, 11 deficiencies were identified. Two of 11 were repeat violations (see Statement of Deficiency 8IRI11, dated 10/15/2021). The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 3	{M 000}		
{M 114}	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or	{M 114}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{M 114}	Continued From page 1 property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 service providers had background checks. Caregiver D, Caregiver E, and Caregiver G did not have a complete background check. A complete background check consists of the following: - A completed Background Information Disclosure (BID) form. - A report of findings from the Department of Justice (DOJ). - Integrated Background Information System (IBIS) letter from the Department of Health Services (DHS). This is a repeat deficiency. See Statement of Deficiency 8IRI11, dated 10/15/2021. Findings include: On 02/01/2024, at 1:45 PM, Surveyor reviewed employee records and identified the following:	{M 114}		

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{M 114}	Continued From page 2 Caregiver D was hired on 07/03/2023. Caregiver D's record contained a BID, dated 07/03/2023. Caregiver D's record did not contain a report of findings from the DOJ or an IBIS letter from the DHS. Caregiver E was hired on 09/20/2023. Caregiver E's record contained a BID, dated 10/09/2023. Caregiver E's record did not contain a report of findings from the DOJ or an IBIS letter from the DHS. Caregiver G was hired on 08/09/2023. Caregiver G's record contained a BID, dated 08/03/2023. Caregiver G's record did not contain a report of findings from the DOJ or an IBIS letter from the DHS. On 02/05/2024, at 4:00 PM, Surveyor interviewed Administrator A regarding background checks of caregivers. Administrator A reported it was his/her responsibility to ensure each staff person had a completed background check. Administrator A confirmed there were no findings from the DOJ or an IBIS letter in the files. Administrator A reported due to a health issue in 08/2023, s/he was unable to perform her/his duties and relied on Caregiver B to assist. Administrator A reported s/he returned to her/his duties in 01/2024, with limitations. Administrator A reported s/he was unable to navigate stairs and could not review staff records as they were kept in the basement. Cross Reference Z0010 DHS 50.065(2)(bb) Determine Final Disposition Of Charge	{M 114}		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the	M 216		

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M 216	Continued From page 3 home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observations, record review, and interview, the provider did not ensure the home and its operation complied with all governing laws related to resident rights, staff trainings, and a safe home environment. Findings include: The provider is licensed to care for up to 3 residents in the following client groups: emotionally disturbed/mental illness, physically disabled, traumatic brain injury, and developmentally disabled. On 02/01/2024, with information gathered through 02/05/2024, the Department conducted a complaint investigation and verification visit. Based on observations, record review, and interviews, the following deficiencies were identified: 88.03(3)(b) Criminal Records Check (REPEAT) 88.04(2)(a) Responsibilities 88.04(2)(g)1 Health Screening For Staff 88.04(2)(h) Comply With Osha 88.04(5)(a) Training- 15 Hours Within 6 Months 88.04(5)(b) Training- 8 Hours Annually (REPEAT) 88.05(4)(b)1 Fire Safety- Smoke Detectors 88.05(4)(c)1 Exiting From The First Floor 88.10(3)(e) Self-Direction 88.10(3)(l) Safe Physical Environment 50.065(2)(bb) Determine Final Disposition Of Charge	M 216		

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M 216	Continued From page 4 On 02/05/2024, at 4:00 PM, Surveyor interviewed Administrator A and Licensee J. Licensee J reported s/he resident in California and Administrator A was responsible for the daily operations of the home. Licensee J reported s/he visited Wisconsin, "every couple of months." Administrator A reported s/he developed health issues in 08/2023, which prevented her/him from performing the duties to oversee daily operations. Administrator A reported s/he returned to the facility in 01/2024. Administrator A reported during the time s/he was unable to perform her/his duties, Caregiver B assisted her/him. Administrator A confirmed Caregiver B was not aware of the code requirements. Administrator A reported due to physical limitations, s/he was unable to navigate stairs. The facility was on the second floor of a duplex and staff records were in the basement. Surveyor asked what plan was in place to ensure the provider followed the codes, Licensee J reported there was no plan in place at this time but would begin to develop one.	M 216		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification.	M 232		

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M 232	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation indicating 1 of 2 staff had been screened for illnesses detrimental, including tuberculosis (TB), to residents, by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service. Caregiver D was not screened for illness detrimental, including TB, to residents. Findings include: On 02/01/2024, at 1:45 PM, Surveyor reviewed Caregiver D's record. Caregiver D was hired on 07/03/2023. Caregiver D's record did not contain evidence Caregiver D was screened for illness detrimental to residents including TB. On 02/05/2024, at 4:00 PM, Surveyor interviewed Administrator A. Administrator A reported s/he was not aware the caregiver's files did not contain documentation of her/his health screening. Administrator A reported due to a health issue in 08/2023, s/he was unable to perform her/his duties and relied on Caregiver B to assist. Administrator A reported s/he returned to her/his duties in 01/2024, with limitations. Administrator A reported s/he was unable to navigate stairs and could not review staff records as they were kept in the basement. Administrator A was unsure if Caregiver D had a communicable disease screening and TB test.	M 232		
M 235	88.04(2)(h) COMPLY WITH OSHA The licensee and all service providers involved in the operation of the adult	M 235		

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M 235	Continued From page 6	M 235		

family home shall comply with the universal precautions contained in the U.S. Occupational Safety and Health Administration Standard 29 CFR 1910.1030 for the control of blood-borne pathogens.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 caregivers received training in standard precautions annually, as required in the U.S. Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 for the control of blood-borne pathogens. Caregiver B and Caregiver F did not receive annual training in standard precautions in 2023.

The OSHA standard requires the employer train each employee with occupational exposure, "At the time of initial assignment to tasks where occupational exposure may take place" per 1910.1030(g) (2)(ii)(A); and "At least annually thereafter," per 1910.1030(g)(2)(ii) (B).

Findings include:

On 02/01/2024, 1:45 PM, Surveyor reviewed staff records and identified the following:

Caregiver B was hired on 11/04/2009. Caregiver B's record did not contain evidence Caregiver B received annual training in standard precautions in 2023.

Caregiver F was hired on 05/20/2020. Caregiver F's record did not contain evidence Caregiver F received annual training in standard precautions

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M 235	Continued From page 7 in 2023. On 02/01/2024, at 2:45 PM, Surveyor interviewed Administrator A. Administrator A reported s/he was not aware Caregiver B and Caregiver F did not have their annual standard precautions training. Administrator A reported due to a health issue in 08/2023, s/he was unable to perform her/his duties and relied on Caregiver B to assist. Administrator A reported s/he returned to her/his duties in 01/2024, with limitations. Administrator A reported s/he was unable to navigate stairs and could not review staff records as they were kept in the basement. Cross Reference M0246 DHS 88.04(5)(b) Training- 8 Hours Annually	M 235		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 staff received required training within 6 months of hire. Caregiver D did not receive resident rights	M 244		

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M 244	Continued From page 8	M 244		

training and first aid training.
Caregiver F did not receive resident rights training.

Findings include:

On 02/01/2024, at 1:45 PM, Surveyor reviewed caregiver records and identified the following:

Caregiver D was hired on 07/03/2023. Caregiver D's record did not contain evidence Caregiver D received resident rights training and training in first aid.

Caregiver F was hired on 05/20/2020. Caregiver F's record did not contain evidence Caregiver F received resident rights training.

On 02/01/2024, at 1:50 PM, Surveyor interviewed Caregiver D regarding training received. Caregiver D reported her/his training included emergency drills, medication refresher, and documentation. Caregiver D reported s/he did not recall having resident rights training or first aid after s/he was hired.

On 02/01/2024, at 2:40 PM, Surveyor interviewed Administrator A. Administrator A reported s/he was not aware Caregiver D and Caregiver F did not have all the required initial trainings. Administrator A reported due to a health issue in 08/2023, s/he was unable to perform her/his duties and relied on Caregiver B to assist. Administrator A reported s/he returned to her/his duties in 01/2024, with limitations. Administrator A reported s/he was unable to navigate stairs and could not review staff records as they were kept in the basement.

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{M 246}	Continued From page 9	{M 246}		
{M 246}	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers completed 8 hours of training approved by the licensing agency related to health, safety, welfare, rights, and treatment of residents every year beginning with the calendar year after the year in which the initial training was received. Caregiver B and Caregiver F did not receive 8 hours of annual training in 2023. This is a repeat deficiency. See Statement of Deficiency 8IRI11, dated 10/15/2021. Findings include: On 02/01/2024, 1:45 PM, Surveyor reviewed staff records and identified the following: Caregiver B was hired on 11/04/2009. Caregiver B's record did not contain evidence Caregiver B received 8 hours annual training in 2023. Caregiver F was hired on 05/20/2020. Caregiver F's record did not contain evidence Caregiver F	{M 246}		

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{M 246}	Continued From page 10 received 8 hours annual training in 2023. On 02/01/2024, at 2:40 PM, Surveyor interviewed Administrator A. Administrator A reported s/he was not aware Caregiver B and Caregiver F did not have their annual training. Administrator A reported s/he had health issues last year and was unable to stay up to date on the requirements. Cross Reference M0235 DHS 88.04(2)(h) Comply With Osha	{M 246}		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a smoke detector in 2 of 4 required locations. There was no smoke detector on the ceiling of the shared resident bedroom and in the hallway.	M 334		

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M 334	Continued From page 11 Findings include: On 02/01/2024, at 1:30 PM, Surveyor toured the facility and identified the following: -Resident 1 and Resident 2's shared bedroom did not contain a smoke detector. -The hallway adjacent to the bedrooms did not contain a smoke detector. On 02/01/2024, at 3:25 PM, Surveyor interviewed Resident 2 regarding her/his missing smoke detector. Resident 2 reported the smoke detector had been missing for approximately 5 months. Resident 2 reported s/he was unsure how long the hallway smoke detector had been missing. On 02/01/2024, at 3:00 PM, Surveyor interviewed Administrator A. Administrator A reported s/he was unaware of the missing smoke detectors. Administrator A reported due to health issues, s/he was unable to navigate the steps to the 2nd floor, where the adult family home was located.	M 334		
M 338	88.05(4)(c)1 EXITING FROM THE FIRST FLOOR Exiting from the first floor. The first floor of the home shall have at least 2 means of exiting which provides unobstructed access to the outside. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 2 exits provided unobstructed access to the outside. The side exit, identified as	M 338		

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M 338	Continued From page 12	M 338		

an emergency exit, contained an engaged keyed deadbolt, which required a key to unlock it. Caregivers did not have the key to unlock the door.

Findings include:

On 02/01/2024, at 1:35 PM, Surveyor toured the facility and observed the following:

The facility was located on the 2nd floor of a duplex. At the top of the stairs of the second floor, one could turn left into the facility or right to the exit. The exit, identified as an emergency exit, led to exterior stairs to sidewalk. The door contained a keyed deadbolt, which was engaged. Surveyor was unable to open the door. Caregiver D retrieved the house keys for the facility to find the correct key to unlock the deadbolt. Caregiver D tried every key and could not locate the key to unlock the deadbolt.

On 02/01/2024, at 1:45 PM, Surveyor interviewed Caregiver D. Caregiver D confirmed the door required a key to unlock the deadbolt and s/he could not find it. Caregiver D reported the door had been locked since s/he began employment in 07/2023.

On 02/01/2024, at 3:25 PM, Surveyor interviewed Resident 2. Resident 2 reported s/he was admitted to the facility in 2020. Resident 2 reported the exit had been locked for "a couple of years." Surveyor inquired how s/he would evacuate in the event of a fire. Resident 2 stated, "We'd jump out a window."

On 02/01/2024, at 3:50 PM, Surveyor interviewed Administrator A. Administrator A confirmed the door was locked and a key was required to

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M 338	Continued From page 13 unlock the deadbolt from inside. Administrator A reported s/he was unable to navigate the stairs and had not been upstairs since August 2023.	M 338		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the provider did not ensure the residents had the opportunity to make decisions related to care, activities, and other aspects of life for 2 of 2 residents. Resident 1 and Resident 2 were unable to make decisions on when, where, and what to eat, did not have access to food, were not able to rise each morning at his/her request, and could not remain in her/his home during the day. Findings include: On 10/09/2023, the Department received a complaint alleging the pantry was locked and residents could not get food when hungry. On 02/01/2024, Surveyor reviewed the	M 556		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 556	Continued From page 14	M 556		

Department's facility file. There was no documentation of waivers or client rights limitation.

On 02/01/2024, at 1:00 PM, Surveyor toured the facility and observed the facility was located on the second floor of a duplex. There was another facility, owned/operated by the licensee, on the first floor. The facility's common refrigerator did not contain any food items or drinks for the residents. The cabinets contained less than 6 canned food items, and there were no plates or cups in the facility.

On 02/01/2024, at 1:15 PM, Surveyor interviewed Caregiver D. Caregiver D reported the facility meals were cooked in the downstairs facility and the food was stored there. Caregiver D reported the residents usually ate their meals downstairs. Caregiver D reported the food was moved downstairs due to a former resident who had behaviors which included eating the food supply.

02/01/2024, at 2:10 PM, Surveyor interviewed Resident 1. Resident 1 confirmed there was no food stored in the facility. Resident 1 reported the residents were only allowed to eat at mealtimes and if s/he wanted a snack, s/he would have to ask staff. Resident 1 reported on the weekends, residents had to eat their meals at the downstairs facility. Resident 1 reported s/he had to remain downstairs during the day and evening. Resident 1 reported the sleeping schedule was from approximately 8:00 PM until 5:00 AM. Residents were brought downstairs to eat breakfast at 5:30 AM. Resident 1 reported s/he would like to go to bed at 8:00 PM and sleep until 7:00 AM. When asked if s/he was able to make decisions around sleep/wake schedules, Resident 1 stated, "We can't." Resident 1 reported residents had to

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	0013710	A. BUILDING: _____ B. WING _____	R-C 02/05/2024

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shower, use the bathroom, and take medications in the first-floor facility. Resident 1 reported s/he preferred to be upstairs. Resident 1 stated, "I can't lay down." Resident 1 reported s/he was not able to make a snack or had the "luxury to make [food] ourselves."

On 02/01/2024, at 2:30 PM, Surveyor interviewed Person H and Person I, residents of the first-floor facility. Person H and Person I confirmed the residents from the second-floor facility ate their meals, took showers, and medications in the first-floor facility. Person H reported the residents from upstairs had been staying downstairs for about a year. Surveyor asked what they did during the day when the upstairs residents were present in the downstairs facility, Person I stated, "We stay in our rooms."

On 02/01/2024, at 3:05 PM, Surveyor interviewed Resident 2 regarding her/his daily schedule. Resident 2 reported the following: S/He woke up around 5:00 AM, and went to breakfast at 5:30 AM, which was served downstairs. After breakfast, s/he would smoke, receive her/his medications, and get ready for work. Resident 2 reported s/he worked Monday through Friday, from 8:30 AM-2:30 PM. Resident 2 reported s/he showered, ate meals, and watched television in the downstairs facility. Resident 2 reported dinner was around 5:00 PM and usually served downstairs. On occasion, meals were served upstairs. Resident 2 reported s/he would "rather be upstairs." Surveyor asked if s/he had spoken to management and Resident 2 stated, "Those the rules they got here."

On 02/01/2024, at 3:30 PM, Surveyor interviewed Administrator A. Administrator A reported s/he was unaware there was no food in the facility and

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M 556	Continued From page 16 instructed staff to bring food items upstairs. Administrator A reported s/he had been out with health issues since 08/2023 and recently returned in 01/2024. Administrator A reported s/he was unable to negotiate the stairs and could not go upstairs. Administrator A reported the residents spent time downstairs in the other facility and it was their preference. Administrator A reported Resident 1 was able to sit outside to smoke and took walks as long as s/he liked. On 02/01/2024, at 5:00 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 08/01/2021. Resident 1's individual service plan, dated 09/04/2023, identified Resident 1 was not a choking risk, able to make small meals, and did not have destructive behaviors. On 02/05/2024, at 2:45 PM, Surveyor interviewed Person K. Person K reported s/he was Resident 1's case manager. Person K reported s/he conducted home visits every 3 months and monthly phone calls. Surveyor asked where Person K and Resident 1 met during their visits. Person K stated, "We visit downstairs in the kitchen." Person K reported Resident 1 did not require 1:1 supervision. Resident 1 could be left alone to smoke and be alone in her/his room for periods of time. Residents were not allowed to make decisions related to care, activities, and other aspects of their life.	M 556		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when	M 570		

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they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability.

This Rule is not met as evidenced by:
Based on observation, and interview, the provider did not ensure water temperatures were kept at a safe temperature for 1 of 1 resident bathroom. The hot water temperature in the resident bathroom was 122° Fahrenheit (F).

Findings include:

On 02/01/2024, at 1:30 PM, Surveyor tested the hot water temperature of faucet in the resident's bathroom. The water temperature was 122° F. Residents were observed utilizing the bathroom unsupervised.

Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA

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M 570	Continued From page 18 Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017.) On 02/01/2024, at 2:35 PM, Surveyors interviewed Administrator A regarding the hot water in the resident bathroom. Administrator A was unaware the water temperature was 122° F. Administrator A reported s/he would turn down the water heater.	M 570		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every	Z 010		

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Z 010	Continued From page 19 reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not make reasonable efforts to contact the clerk of courts to obtain copies of the judgments of conviction and criminal complaint after 1 of 1 staff (Caregiver D) disclosed a disorderly conduct conviction within the previous 5 years. Findings include: On 02/01/2024, at 1:45 PM, Surveyor reviewed Caregiver D's record. Caregiver D was hired 07/03/2023. Caregiver D's background information disclosure form was dated 07/03/2023. There was no documentation of a Department of Justice (DOJ) report. On 02/02/2024, at 10:45 AM, Surveyor received and reviewed records sent electronically. A DOJ report, dated 02/01/2024, identified Caregiver D was convicted of disorderly conduct in violation of Wisconsin State Statute 947.01(1) on 11/28/2023. There was no additional information. On 02/05/2024, at 4:00 PM, Surveyor interviewed Administrator A and Licensee J. Administrator A and Licensee J confirmed they did not obtain a copy of the judgment of conviction and criminal complaint. Administrator A reported due to health issues, s/he was unable to perform the duties of administrator. Administrator A reported Caregiver B was assisting her/him with the duties.	Z 010		

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Z 010	Continued From page 20 Cross Reference M0114 DHS 88.03(3)(b) Criminal Records Check	Z 010		