STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155813	A. BUILDING 00 B. WING	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAGES AT HISTORIC SILVERCREST THE	1 SILVERCREST DRIVE NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 15, 16, 17, 18, 19, and 22, 2024 Facility number: 012619 Provider number: 155813 AIM number: 201238590 Census Bed Type: SNF: 37 SNF/NF: 9 Residential: 29 Total: 75 Census Payor Type: Medicare: 23 Medicaid: 9 Other: 14 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 24, 2024.	F 0000	This plan of correction is to serve as The Historic Villages of Silvercrest Health Campus credible allegation of compliance. Submission of this plan of correction does not constitute an admission by The Historic Villages of Silvercrest Health Campus or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find the plan of correction for The Historic Villages of Silvercrest Health Campus annual survey that was completed on 7/22/2024. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is: 8/7/2024. We initiated immediate interventions when concerns were identified during recertification survey. The facility respectfully requests from the department a desk review for substantial compliance. If you need any information or paperwork, please contact me at 1(812)542-6720.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Victoria Roby Harper	Executive Director	08/08/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			Sincerely, Tori Harper, Executive Director	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			

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	Based on record review and interview, the facility failed to monitor and appropriately document observation of the resident's urinary output for 1 of 2 residents reviewed for bladder incontinence. (Resident 11) Findings include: The record for Resident 11 was reviewed on 7/21/24 at 1:30 p.m. The diagnoses included, but were not limited to, sepsis, urinary tract infection, acute kidney failure, overactive bladder, and dementia. The care plan, dated 5/6/24, indicated the resident experienced episodes of incontinence. The interventions included, but were not limited to encourage fluids unless contraindicated, observe for signs and symptoms of UTI (Urinary Tract Infection) and notify the physician as needed, observe skin and report any signs of breakdown as needed, offer and assist with toileting as needed and/or per request, provide incontinence care as needed, and provide incontinence products as needed. The physicians' orders, dated 5/6/24, indicated to monitor urinary output due to the removal of the resident's indwelling Foley catheter three times a day. If there was no void in 8 hours, complete straight catheter using a regular Foley and if greater than 250 ml output, re-anchor the Foley catheter. The nurse's note, dated 5/6/24 at 9:20 p.m., indicated the resident's Foley catheter and midline were both discontinued during the shift. The resident tolerated both procedures well. A pressure dressing was applied to RUE (Right Upper Extremity) following removal of the midline.	F 0690	***F690 Bowel/Bladder Incontinence, Catheter, UTI*** ***What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** *Resident 11 was sent to the hospital at time of incident and treated at hospital for UTI, urinary retention, and sepsis. DHS provided education to nursing staff regarding monitoring urinary output after foley catheter removal. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** *All residents with foley catheters with orders to remove foley catheter have the potential to be affected. No orders in place for foley catheter removal. No other residents have been identified for the potential to be affected by the deficient practice. *All residents that have recurrent UTI's have the potential to be affected. All residents reviewed for recurrent UTI's, residents identified were confirmed with being currently on prophylactic UTI treatment and/or physician notified and requested prophylactic treatment. ***What measures will be put in**	08/07/2024

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	The resident would be monitored to ensure that she was able to void without difficulty. The IDT (Interdisciplinary Team) urinary notes, dated 5/7/24 at 11:50 a.m., indicated the resident was admitted with a catheter and an order was received to discontinue the catheter and monitor for output. If the resident did not void within 8 hours complete an in and out catheterization and anchor if over 250 mL (milliliters). If indicated do a urine dip and send out for a urinalysis and a culture and sensitivity if indicated. The review of the urinary output documentation indicated the following: - On 5/7/24 the resident urinated a medium amount of urine at 8:15 p.m. Documentation dated 5/8/24 at 12:42 a.m., indicated zero urine output. The resident urinated a large amount of urine at 1:49 p.m. The resident did not urinate for 15.5 hours. - On 6/12/24 the resident urinated a medium amount of urine at 2:21 a.m. Documentation dated 6/12/24 at 12:57 p.m., indicated zero urine output. The resident urinated a large amount of urine on 6/13/24 at 5:45 a.m. The resident did not urinate for 22.5 hours. The resident's record lacked documentation and monitoring of the resident's urine output during the long time durations of no voiding. The nurse's note, dated 5/12/24 at 5:48 p.m., indicated the emergency room called the facility and indicated the resident was admitted to the hospital with a diagnosis of sepsis, urinary tract infection and urinary retention. The Five Day Scheduled Minimum Data Set		**place or what systemic changes will you make to ensure that the deficient practice does not recur;** *Education provided to nursing staff, upon discontinuation of foley catheter, staff will monitor and record urinary output at minimum of every 8 hours and if there is no void in 8 hours, staff will follow physician parameters for straight catheterization or anchoring foley catheter and notify physician of abnormal urinary output. *Staff education to nurses for an event will be opened upon removal of foley catheter at time of removal with nurse monitoring every 8 hours for abnormal urinary symptoms including output. *Education provided to nursing staff to monitor for recurrent UTI's and notify physician with request to initiate prophylactic UTI treatment. ***How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice?** * DHS and IDT team to monitor all foley catheters to ensure foley catheter event in place and monitor for documentation daily upon removal to ensure urinary output is monitored and charted at minimum of every 8 hours and	

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	(MDS) assessment, dated 5/24/24, indicated the resident was cognitively severely impaired. The resident required maximum assistance with toileting. The nurse's note, dated 6/12/24 at 7:56 p.m., indicated during the p.m. medication pass the resident seemed more lethargic than baseline and the resident's family member agreed. The resident was alert and oriented times 2. Her vital signs were WNL (within normal limits), her temperature was 99.2 degrees Fahrenheit. The resident denied any pain and was able to take medication with no concerns. The resident took a long time to answer questions and would stare off at times and required redirection. Her respirations were even and unlabored. She had active bowel sounds in all 4 quadrants; her lungs were clear in all fields. The NP (Nurse Practitioner) was notified, and she ordered to obtain CBC (Complete Blood Count) and dip her urine and send to the laboratory if the results were positive. The review of the resident's fluid and food intake indicated the following: Breakfast - On 5/8/24 the resident did not eat breakfast - On 6/12/24 the resident consumed 76% to 100% - On 7/10/24 the resident consumed 76% to 100% Lunch - On 5/10/24 the resident consumed 51% to 75% - On 6/12/24 the resident did not eat lunch - On 7/10/24 the resident consumed 26% to 50% Dinner - On 5/8/24 the resident consumed 1% to 25% - On 6/12/24 the resident consumed 76% to 100% - On 7/10/24 the resident consumed 26% to 50%		nurses monitoring and charting on urinary output every shift. To complete audit three days weekly x 2 weeks, then twice weekly x 2 weeks, once weekly x 2 months, then once monthly x3 months. Findings will be reviewed during the campus' quarterly QAPI committee. Findings suggestive of 100% compliance may result in cessation of the monitoring plan. *DHS, IP and IDT team to monitor residents with recurrent UTI's with physician notification with request for prophylaxis UTI treatment.	

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	Fluid intake - On 5/10/24 the resident's fluid intake was 480 mL - On 6/12/24 the resident's fluid intake was 720 mL - On 7/10/24 the resident's fluid intake was 1820 mL - On 7/10/24 the resident urinated a large amount of urine at 7:13 p.m. The documentation dated 7/10/24 at 11:08 p.m., indicated zero urine output. The resident urinated a large amount of urine on 7/11/24 at 4:57 a.m. The resident did not urinate for 9.5 hours. The clinical record indicated the resident was admitted to the hospital on 5/12/14 and 7/16/24. During an interview on 07/19/24 09:48 a.m., LPN (Licensed Practical Nurse) 5 indicated typically when a resident hadn't urinated for 8 hours the NP (Nurse Practitioner) would be notified. The facility was working with the NP to implement a time frame for when a resident should urinate. During an interview 7/19/24 at 11:04 a.m., the DON (Director of Nursing) indicated at the time the CNA (Certified Nursing Aide) documented in the record, the resident had not urinated. The CNA did not go back in and chart the output at the end of her shift. She indicated she educated the staff on documenting their charting at the end of their shift. The review of the staff education record indicated the following: - On 5/10/24 the documentation indicated CNA 6 documented on 5/8/24 at 12:30 a.m., the resident had no urine output. The CNA indicated that the resident had urinated around 4:00 a.m.			

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	- On 6/15/24 the documentation indicated the resident did not have an output on 6/12/24 on the night shift. CNA 7 documented on 6/12/24 at 10:45 p.m. The CNA indicated the resident urinated around 3:15 a.m. - On 7/13/24 the documentation indicated CNA 7 documented that the resident did not have a urine output on 7/10/24 on the night shift. This was documented on 7/10/24 at 11:00 p.m. The CNA indicated the resident urinated around 2:20 a.m. During an interview on 7/19/24 at 12:15 p.m., LPN 8 indicated the residents were checked and changed every 2 hours. She would not let a resident go any longer than 6 hours without urinating. She would call the doctor. During an interview on 7/19/24 at 12:30 p.m., CNA 9 indicated she would do her output charting at the end of her shift. She had been educated on when to chart the outputs. If she had a resident that did not urinate, she would tell the nurse. An attempt was made to call CNA 7 and LPN 10 without an answer and voicemail messages were left to return the call. No return call was received. The Bladder Continence policy, dated 12/31/23, included, but was not limited to, "...To provide measures for a resident who is incontinent to receive appropriate treatment and services to prevent urinary tract infection and to restore as much normal bladder function as possible ...10. Toileting and continence interventions shall be communicated to care givers via the resident profile ..." 3.1-41(a)(2)			

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure the kitchen equipment was clean and free from grease and food particles for 3 of 3 kitchen observations. This deficient practice had the potential to affect 46 residents currently residing on the 200 and 300 Halls. Findings include: During an initial tour of the kitchen on 7/15/24 at 9:28 a.m., the following was observed: -A saucer sized whitish/yellow unknown mound was observed on the floor behind the double door	F 0812	***F812 Food Procurement, Store/Prepare/Serve-Sanitary*** ***What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** *Based on observations and interview by the ISDH, the facility failed to ensure the kitchen and equipment were clean and in good repair for 2 of 2 kitchen observations. No residents within	08/07/2024

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	heating oven. -Aluminum foil was in the drip pan under the stove top. - The stove top burners had a buildup of black charcoal, which had crackled on the surface area in the back of the burners. -The grill had black grease on the front surface of the grill grates and there was a buildup of black charcoal chunks between the grates. -The deep fryer had food particles on the front edge counter of the grease basin. -The vents had dust hanging down between the stove top and the steam table and preparation area. There were black areas in the vent holes above the area between the grill, stove, and heating oven, wrapping around above the side of the heating oven. -The floor in front of the stove, oven and grill was slippery with a greasy feel. There was a wet slippery puddle in front of the grill, which appeared to be oil. During a second tour of the kitchen on 7/17/24 at 8:22 a.m., the following was observed: -The aluminum foil was still observed in the drip pan under the stove top. -The stove top burners still had a buildup of black charcoal, which had crackled on the area in the back of the burners. -The grill still had black grease on the front surface of the grill grates and there was a buildup		the campus were found to have been affected by the alleged deficient practice. All items of concern were corrected, cleaned and/or removed. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** *The deficient practice had the potential to affect 47 our of 47 residents that received food from the kitchen. No residents identified with the potential to be affected have been noted with any affects of the alleged deficient practice. ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** *The Dining Service Support provided education regarding proper cleaning of the kitchen to all dietary staff on date 8/1/2024 ***How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice?**	

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	of black charcoal chunks on the grates. -The 2 drip pans under the grill had a heavy amount of black charcoal mounds and grease, which reached the underside of the grill. -The fryer had food particles on the front edge counter of the grease basin. -The wire under the oven doors still had a 5-inch area without the cloth covering. -The vents still had dust hanging down between the stove top and the steam table and preparation area. There were black areas in the vent holes above the area between the grill, stove, and heating oven, wrapping around above the side of the heating oven. -The floor in front of the stove, oven and grill was still slippery with a greasy feel. There was a wet slippery puddle in front of the grill, which appeared to be oil. During a return tour of the kitchen on 7/19/24 at 8:52 a.m., the same issues were observed as well as the following: -Streaks of brown grease was observed down the right side of the stove. -The dust on the vents was hanging lower, between the stove top and the steam table and preparation area. There were black areas in the vent holes above the area between the grill, stove, and heating oven, wrapping around above the side of the heating oven. During an interview on 7/17/24 at 8:26 a.m., the Dietary Manager indicated the equipment was		*The Director of Dining Services and/or Executive Director will perform random observation audits of the kitchen to check for cleanliness three times per week for one month, then once weekly for three months, then monthly x three months. Findings will be reviewed during the campus' quarterly QAPI committee. Findings suggestive of 100% compliance may result in cessation of the monitoring plan. **Date of compliance 08/07/2024**	

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	cleaned weekly with specific scheduled tasks, to be completed each day on both shifts. Once a week on Saturdays, the floors were cleaned. She did not mention that the equipment was cleaned as needed. She provided the schedule which indicated the following: -On Monday, the a.m. cook was to clean the convection oven and the p.m. cook was to clean the stovetop burners and boil out fryer. -On Tuesday, the a.m. cook was to clean the flat top, drip pans, and the stove backsplash. The p.m. cook was to clean the steamer. -The Friday p.m. cook was to clean the hood vents. During a follow up interview on 7/19/24 at 8:54 a.m., the Dietary Manager indicated staff would clean the equipment as needed along with the scheduled cleaning days and shifts, if a problem was observed. She felt that the stove would take time to clean the charcoal off the top. They had been chipping away at the buildup. The vents were cleaned on Fridays on the p.m. shift. The 15 Minutes of Cleaning policy, dated 2/7/23, included, but was not limited to, " ... For a 15-minute timeframe every day, your team will be working together on kitchen sanitation practices ... Many other items need to be cleaned inside of our kitchens that are not on our weekly cleaning schedules ..." 3.1-21(i)(3)			
R 0000 Bldg. 00				

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	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 15, 16, 17, 18, 19, and 22, 2024 Facility number: 012619 Residential Census: 29 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on July 24, 2024.	R 0000	This plan of correction is to serve as The Historic Villages of Silvercrest Health Campus credible allegation of compliance. Submission of this plan of correction does not constitute an admission by The Historic Villages of Silvercrest Health Campus or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find the plan of correction for The Historic Villages of Silvercrest Health Campus annual survey that was completed on 7/22/2024. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is: 8/7/2024. We initiated immediate interventions when concerns were identified during recertification survey. The facility respectfully requests from the department a desk review for substantial compliance. If you need any information or paperwork, please contact me at 1(812)542-6720. Sincerely, Tori Harper, Executive Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155813	A. BUILDING 00 B. WING	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAGES AT HISTORIC SILVERCREST THE	1 SILVERCREST DRIVE NEW ALBANY, IN 47150

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure the kitchen equipment was clean and free from grease and food particles for 3 of 3 kitchen observations. This deficient practice had the potential to affect 29 residents currently residing on the Assisted Living floors. Findings include: During an initial tour of the kitchen on 7/15/24 at 9:28 a.m., the following was observed: -A saucer sized whitish/yellow unknown mound was observed on the floor behind the double door heating oven. -Tin foil was in the drip pan under the stove top. - The stove top burners had a buildup of black charcoal, which had crackled on the surface area in the back of the burners. -The grill had black grease on the front surface of the grill grates and there was a buildup of black charcoal chunks between the grates. -The deep fryer had food particles on the front edge counter of the grease basin. -The vents had dust hanging down between the stove top and the steam table and preparation area. There were black areas in the vent holes	R 0273	***F812 Food Procurement, Store/Prepare/Serve-Sanitary*** ***What Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;** *Based on observations and interview by the ISDH, the facility failed to ensure the kitchen and equipment were clean and in good repair for 2 of 2 kitchen observations. No residents within the campus were found to have been affected by the alleged deficient practice. All items of concern were corrected, cleaned and/or removed. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** *The deficient practice had the potential to affect 47 our of 47 residents that received food from the kitchen. No residents identified with the potential to be affected	08/07/2024

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	above the area between the grill, stove, and heating oven, wrapping around above the side of the heating oven. -The floor in front of the stove, oven and grill was slippery with a greasy feel. There was a wet slippery puddle in front of the grill, which appeared to be oil. During a second tour of the kitchen on 7/17/24 at 8:22 a.m., the following was observed: -The tin foil was still observed in the drip pan under the stove top. -The stove top burners still had a buildup of black charcoal, which had crackled on the area in the back of the burners. -The grill still had black grease on the front surface of the grill grates and there was a buildup of black charcoal chunks on the grates. -The 2 drip pans under the grill had a heavy amount of black charcoal mounds and grease, which reached the underside of the grill. -The fryer had food particles on the front edge counter of the grease basin. -The wire under the oven doors still had a 5-inch area without the cloth covering. -The vents still had dust hanging down between the stove top and the steam table and preparation area. There were black areas in the vent holes above the area between the grill, stove, and heating oven, wrapping around above the side of the heating oven.		have been noted with any affects of the alleged deficient practice. ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;** *The Dining Service Support provided education regarding proper cleaning of the kitchen to all dietary staff on date 8/1/2024 ***How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e…, what quality assurance program will be put into practice?** *The Director of Dining Services and/or Executive Director will perform random observation audits of the kitchen to check for cleanliness three times per week for one month, then once weekly for three months, then monthly x three months. Findings will be reviewed during the campus' quarterly QAPI committee. Findings suggestive of 100% compliance may result in cessation of the monitoring plan.	

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	-The floor in front of the stove, oven and grill was still slippery with a greasy feel. There was a wet slippery puddle in front of the grill, which appeared to be oil. During a return tour of the kitchen on 7/19/24 at 8:52 a.m., the same issues were observed as well as the following: -Streaks of brown grease was observed down the right side of the stove. -The dust on the vents was hanging lower, between the stove top and the steam table and preparation area. There were black areas in the vent holes above the area between the grill, stove, and heating oven, wrapping around above the side of the heating oven. During an interview on 7/17/24 at 8:26 a.m., the Dietary Manager indicated the equipment was cleaned weekly with specific scheduled tasks, to be completed each day on both shifts. Once a week on Saturdays, the floors were cleaned. She did not mention that the equipment was cleaned as needed. She provided the schedule which indicated the following: -On Monday, the a.m. cook was to clean the convection oven and the p.m. cook was to clean the stovetop burners and boil out fryer. -On Tuesday, the a.m. cook was to clean the flat top, drip pans, and the stove backsplash. The p.m. cook was to clean the steamer. -The Friday p.m. cook was to clean the hood vents. During a follow up interview on 7/19/24 at 8:54		**Date of compliance 08/07/2024**	

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	a.m., the Dietary Manager indicated staff would clean the equipment as needed along with the scheduled cleaning days and shifts, if a problem was observed. She felt that the stove would take time to clean the charcoal off the top. They had been chipping away at the buildup. The vents were cleaned on Fridays on the p.m. shift. The 15 Minutes of Cleaning policy, dated 2/7/23, included, but was not limited to, " ... For a 15-minute timeframe every day, your team will be working together on kitchen sanitation practices ... Many other items need to be cleaned inside of our kitchens that are not on our weekly cleaning schedules ..."			