

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 686125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER The Lilac at Silver Palms		STREET ADDRESS, CITY, STATE, ZIP CODE 14601 NE 16th St North Miami, FL 33161	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure medications and biologics were properly stored in two out of two medication rooms (First floor and Second floor medication rooms). As evidenced by: Expired saline and sterile water on the second-floor treatment cart, eye drops observed at Resident # 5's bedside; ointment and medications observed in residents' rooms at bedside (Resident #7, Resident # 15, Resident #31, Resident #60, Resident #76 and Resident #108). Expired Intravenous (IV) start kits and alcohol pads found in the first-floor medication room, expired liquid Lansoprazole for Resident#4 in the second-floor medication room and expired insulin for Resident # 68 found in the first-floor medication cart. There were 94 residents residing in the facility at the time of the survey. The findings include. Resident # 31 Observation on 02/17/2026 at 10:08 AM in Resident # 31's room revealed lanolin-petrolatum ointment (A&D ointment) on top of the resident's dresser. (Photo evidence) Review of the medical records for Resident #31 revealed the resident was admitted to the facility on [DATE]. Clinical diagnosis includes Xerosis Cutis. Resident # 108 On 02/17/2026 at 10:10 AM Zinc Oxide ointment was observed on Resident # 108's bedside dresser. (Photo evidence) Review of the medical records for Resident #108 revealed the resident was admitted to the facility on [DATE]. Clinical diagnosis includes Xerosis Cutis Resident #15 On 02/18/2026 at 9:47 AM Zinc Oxide and A&D ointments were observed on Resident #15's bedside table. (Photo evidence) Review of the medical records for Resident #15 revealed the resident was admitted to the facility on [DATE]. Clinical diagnosis included Xerosis Cutis. Review of Residents #15, #31 and #108's Physician's Orders Sheet revealed the residents did not have any orders for zinc oxide or A&D ointment. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/20/2025 at 03:00 PM the Director of Nursing (DON) stated Ointments such as A&D and zinc oxide should only be kept in a resident's room with a physician's order. Residents must have a valid order before these topical treatments can be used or stored at the bedside. Even when an order is present, the ointments should be stored safely in a drawer or designated secure area to prevent accidents and maintain resident safety. Medications should not be left at the resident's bedside or on the bedside table at any time. Resident # 60 Observation on 02/17/2026 at 8:39 AM in Resident #60's room revealed a tube of Mupirocin ointment on the nightstand. (Photo evidence). On 02/17/2026 at 9:13 AM Staff B, Licensed Practical Nurse (LPN) was made aware of the identified concern and removed ointment. Staff B, LPN revealed nurses and Certified Nursing Assistants (CNA)s are responsible for checking residents' belongings and removing any medications and educating the residents. All medications or ointments are to be kept in a locked cart and not in residents' rooms. Record review of Resident # 60's clinical records indicated the resident was admitted on [DATE] with diagnosis that included but not limited to: Other Acute Osteomyelitis. Record review of the February 2026 physician orders sheet revealed: no orders for Mupirocin. Resident # 5 Observation on 02/17/2026 at 9:40 AM in Resident # 5's room a bottle of eye drops was at the bedside. (Photo evidence). Record review of Resident #5's clinical records indicated the resident was admitted on [DATE] with diagnosis that included but not limited to: Heart Failure. Record review of the February 2026 physician orders sheet revealed: no orders for eye drops. Resident #76 On 02/17/2026 at 10:10 AM an observation was made of an open drawer next to Resident #76 with a box of medication visible. (Photo evidence). On 02/17/2026 at 10:15 AM, the second-floor south charge nurse LPN was made aware of the finding in Resident # 76's open drawer and removed the medication. Record review of a demographic sheet revealed Resident #76 was admitted on [DATE] with diagnosis that included but not limited to: Gastro-Esophageal Reflux. Record review of February 2026 physician order sheet revealed Resident #76 had an order dated 2/17/2026 for Gas Relief Oral Tablet Chewable (Simethicone). Give 1 tablet by mouth every 8 hours as needed for Gas. Resident #7 Observation in Resident #7's room on 02/17/2026 at 9:49 AM revealed Ciclopirox topical solution on the shelf in the resident's room. (Photo evidence) On 02/18/2026 at 10:58 AM, observation revealed Resident #7 lying in bed the Ciclopirox topical (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	solution was on shelf in the resident's room. (Photo evidence) On 02/19/2026 at 11:25 AM, Resident #7 was in therapy during observation. Ciclopirox topical solution remained on the shelf in the resident's room. Photo evidence. Record review revealed Resident #7 was admitted on [DATE] with a diagnosis of Acute on Chronic Systolic (Congestive) Heart Failure. On 02/19/2026 at 11:15 AM, the Social Services Director stated residents are not allowed to keep medications in their rooms and that prescribed medications remain on the medication cart. On 02/19/2026 at 11:29 AM, the Administrator revealed Resident #7's wife brought the item into the facility and residents are not allowed to have medications in their rooms. On 02/19/2026 at 2:13 PM, Staff F, Licensed Practical Nurse (LPN), stated: Medications are not supposed to be kept in resident rooms. First-Floor Medication Room On 02/17/2026 at 11:10 AM, during a medication storage inspection of the first-floor medication room with the Assistant Director of Nursing (ADON) revealed six Intravenous (IV) start kits with an expiration date of 02/19/2024 and five alcohol pads with an expiration date of 10/09/2025. Second-Floor Medication Room/ Resident #4 Observation on 02/17/2026 at 11:28 AM of the second-floor medication room with the Infection Preventionist revealed a bottle of liquid Lansoprazole for Resident #4 with a label that read discard after 02/07/2026. Record review of a demographic sheet revealed Resident #4 was admitted on [DATE] with diagnosis that included but not limited to: Gastrostomy and Gastro-Esophageal Reflux (GERD). Record review of February 2026 physician order sheet revealed Resident#4 had an order dated 12/25/25 for Lansoprazole Oral Suspension (Lansoprazole) Give 30 milligrams via Percutaneous Endoscopic Gastrostomy (PEG) Tube two times a day related to GERD. Second-Floor Treatment Cart While checking the second-floor treatment cart on 02/17/2026 at 12:35 PM with Staff A, LPN a bottle of sterile water with an expiration date of 10/27/25 and a tube of normal saline expiration date of 10/2025 (photo evidence) was observed. First-Floor Medication Cart/ Resident # 68 A medication storage check completed on the first-floor medication cart with Staff E, Licensed Practical Nurse (LPN) on 02/18/2026 at 12:30 PM revealed an Admelog solo injection insulin pen labeled with Resident # 68's name, open date 1/15/26 and expiration date 2/13/26 stored in medication cart (photo). Staff E, LPN stated: According to the date on the pen it is expired. Record review of the electronic medication administration record revealed Resident #68 was administered Admelog solo injection on 2/17/2026 at 5:36 PM by Staff E, LPN who then stated, I check for the (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to honor residents right to a dignified experience for one (Resident #29) out of one sampled resident with an indwelling cholecystostomy drainage device as evidenced by observation of Resident # 29 receiving physical therapy and the cholecystostomy drainage collection bag was not inside a privacy bag and visible. There was one resident with a cholecystostomy drainage device residing in the facility at the time of survey. The findings included: Observation on 02/18/2026 at 10:27 AM, revealed Resident #29 self-propelling in wheelchair on the 2nd floor hallway towards the therapy room. A cholecystostomy drainage bag was visible (photo). On 02/18/2026 at 10:30 AM Resident # 29 was observed being assisted with ambulation using a walker by the Physical Therapist and Staff D, Occupational therapy assistant. Resident # 29's cholecystostomy drainage bag was visible. On 02/18/2026 at 10:35 AM, Staff B, Licensed Practical Nurse (LPN) was made aware and stated: The drainage bag is to be kept in a privacy bag to provide dignity. During an additional observation on 02/18/2026 at 10:37 AM, Resident # 29 was seated in the therapy room amongst other residents speaking with the Physical Therapist and the cholecystostomy drainage bag visible. Record review of a demographic sheet revealed Resident # 29 was admitted on [DATE] and readmitted on [DATE] with diagnosis that included but not limited to: Fusion of spine, lumbar region. Record review of a Medicare 5- day Minimum Data Set reference dated 01/22/2026 revealed Resident # 29 had a Brief Interview of Mental Status score of 14, indicated no cognitive impairment, was dependent for toileting hygiene, required substantial/ maximal assistance for shower/bathe, partial/moderate assistance for dressing, and had an indwelling catheter. Record review of a care plan initiated 11/26/2025 and revised 02/17/26 revealed Resident # 29 had Activities of Daily Living self-care performance deficit with interventions that included but not limited to: Cholecystostomy care-observe for flush/drainage, signs/symptoms of infection report to Medical Doctor if noted. Record review of a February 2026 physician orders sheet revealed order dated 2/10/26- Observe Cholecystostomy Drainage Catheter Underneath Right Breast for signs and symptoms of infection. During an interview on 02/18/2026 at 10:38 AM, Staff D, Occupational Therapy Assistant and the Physical Therapist revealed they were aware Resident # 29 had a Cholecystostomy drainage catheter but did not realize it was visible today and they would inform nurse if they had noticed it was visible. During an interview with the Director of Nursing on 02/19/2026 at 9:41 AM it was revealed that staff are to place the Cholecystostomy drainage bag in a privacy covering to provide dignity. Record review of facility's policy and procedure titled, Resident Rights-Exercise of Rights date issued: 1/2026 revealed Policy: All residents have rights guaranteed to them under Federal and State laws and regulations. This policy is intended to lay the foundation for the resident rights requirements in long-term care facilities. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices. When providing care and services, staff will respect each resident's individuality, as well as honor and value their input.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, interviews, and record review, the facility failed to protect residents' personal information on one out of four medication carts as evidenced by: 1) facility's staff left paperwork with residents' personal medical information unattended on top of medication cart. 2) Facility's staff failed to close a computer screen before walking away and resident information visible on the second-floor nursing unit. There were three nursing units in the facility at the time of survey. The findings included: Observation on 02/19/2026 at 10:32 AM on the facility's second-floor south unit revealed an unattended medication cart with paperwork that contained residents' personal information visible (photo). On 02/19/2026 at 10:34 AM Staff J, Registered Nurse (RN) exited a room and approached the medication cart and was made aware of the identified concern. Staff J, RN stated: We keep resident's information private by closing our computer screens and shredding documents. This paperwork shouldn't be on top of cart and should have been shredded. On 02/19/2026 at 2:45 PM the Director of Nursing revealed staff are to close computer screens and turn paperwork over to keep resident information private. Observation on 02/19/2026 at 10:40 AM revealed Staff J, RN leaving the 2nd floor medication cart in the hallway with the computer screen open and residents' information visible on screen. Staff B, Licensed Practical Nurse (LPN) was observed walking down the hallway and the closed computer screen. Staff B, LPN was interviewed and stated, I asked [Staff J, RN] to help a resident and she forgot to close the screen, so I closed the computer screen. Record review of facility's policy dated 1/2026 revealed. POLICY: It is the policy of the facility to maintain Medical Records in accordance with State and Federal regulations. 6. The facility will safely guard clinical record information against loss, destruction or unauthorized use.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one (Resident #68) out of one sampled resident receiving insulin injections as evidenced by documentation indicating expired insulin found on the first-floor medication cart was administered to Resident # 68. The findings included: Observation and interview on 02/18/2026 at 12:30 PM during a medication cart inspection conducted on the facility's first floor with Staff E, Licensed Practical Nurse (LPN) revealed an insulin pen (Admelog solo injection) labeled with Resident #68's name with open date 01/15/26 and expiration date 2/13/26 stored in the medication cart (photo). Staff E, LPN stated: According to the date on the pen it is expired. Review of Resident # 68's electronic medication administration record revealed the Admelog solo injection was last administered on 02/17/2026 at 5:36 PM by Staff E, LPN (photo). Staff E, LPN was asked about the facility's medication storage and administration protocols and stated: I check for the correct resident and the expiration date before I administer the medication. Expired insulin should not be stored in cart or administered. Record review of a demographic sheet revealed Resident # 68 was admitted on [DATE] with diagnosis that included but not limited to: Diabetes Mellitus (DM). Record review of a Quarterly minimum data set reference dated 12/5/25 revealed Resident#68 had a Brief Interview of Mental Status score of 3, indicated severe cognitive impairment and injections and was taking Hypoglycemic medications (including insulin). Record review of a care plan initiated: 03/23/2023 and revised: 03/23/2023 revealed Resident#68 had interventions that included: Accu Checks and sliding scale insulin as ordered. Record review of a physician orders sheet revealed: Resident #68 had an order dated 11/12/25 for Admelog Solostar 100 Units per milliliter (unit/mL) Solution pen-injector directions: inject subcutaneously two times a day related to Type 2 DM. On 02/19/2026 at 9:36 AM, the Director of Nursing was made aware of the identified concern and revealed pharmacy staff comes in and check the med carts every two weeks and remove any expired medications. No expired materials are to be kept in the medication rooms or carts. No expired medications are to be administered to residents. During an interview on 02/20/2026 at 7:51 AM the Pharmacist Consultant stated: Opened insulins expire after 28 days and some after 45 days. Review of a listing of insulin with expiration dates provided for review with the Pharmacist Consultant revealed Admelog Solostar insulin pen expired 28 days after opening. Record review of facility's policy and procedure titled, Quality of Care dated 1/2026 revealed Policy: It is the policy of the facility to ensure that each resident receive, and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, in accordance with State and Federal Regulations. Definitions: Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure an environment free of accident hazards as evidenced by razor observed in Resident #7's room, 2) Resident #107 observed with heating pad; 3) Overfilled sharps container in Resident #29's room and 4) Unsecured door with interior lock on second floor south hallway. There were 94 residents residing in the facility at the time of the survey. The findings included. 1) On 02/17/2026 at 9:49 AM, observation revealed Resident # 7 in bed alert there was a shaving razor on the shelf. Photo evidence was obtained. On 02/18/2026 at 10:58 AM, observation revealed a razor on the shelf in Resident #7's room. On 02/19/2026 at 11:25 AM, Resident # 7 was in therapy and the razor remained on the shelf in the resident's room. Photo evidence was obtained. Record review revealed the resident was admitted on [DATE] with diagnoses including Acute on Chronic Systolic (Congestive) Heart Failure. Review of Resident #7's admission Minimum Data Set, dated [DATE] indicated the resident is cognitively intact and required assistance with oral and personal hygiene. Review of Resident #7's Care Plan dated 01/22/2026 with next review date 04/22/2026 focused on arranging the resident's environment to facilitate activities of daily living performance and keeping frequently used items within reach. Interviews on 02/19/2026 at 11:15 AM, the Social Services Director, revealed residents are not allowed to keep razors in their rooms. Alert residents may use razors under supervision, and the razor is removed afterward. If residents are not alert, Certified Nursing Assistants assist with shaving and remove the razor afterward. Interview on 02/19/2026 at 11:29 AM, the Administrator reported the razor was brought in by Resident #7's wife and residents are not allowed to keep the item. On 02/19/2026 at 2:13 PM, Staff F, Licensed Practical Nurse, LPN, stated: Razors are not supposed to be kept in resident rooms. On 02/20/2026 at 3:13 PM, Staff G, Certified Nursing Assistant, CNA, revealed if a potentially harmful item is identified in a resident's room, the item is removed immediately and secured in a safe place. 2) Observation on 02/17/2026 at 9:19 AM revealed Resident #107 in the bathroom performing morning care and a heating pad was observed on the bed (photo). A private aide was at the bedside and revealed Resident#107 uses the heating pad daily. On 02/17/2026 at 9:30 AM Staff C, Certified Nursing Assistant revealed Resident#107 normally uses the heating pad throughout the day. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #107's clinical records revealed the resident was admitted on [DATE] with diagnosis that included but not limited to depression. Record review of an admission Minimum Data Set reference dated 11/15/25 revealed Resident #107 had no cognitive impairment, required supervision or touching assistance for eating/ oral hygiene, partial/moderate assistance for toileting, substantial/maximal for shower/bathe/dressing, partial/moderate assistance for toilet transfer. Record review of a care plan initiated: 11/13/2025 and revised: 11/18/25 revealed Resident #107 had an ADL (Activities of Daily Living) self-care performance deficit with interventions that included but not limited to: Provide cueing for safety and sequencing to maximize current level of function During an interview on 02/18/2026 at 11:06 AM, the second-floor south unit charge Licensed Practical Nurse (LPN) and Staff B, LPN revealed they had no knowledge of Resident#107 using a heating pad. On 02/18/2026 at 12:08 PM Resident #107 revealed the heating pad was used daily due to the cold weather. On 02/18/2026 at 2:45 PM, the Director Nursing was informed of the identified concern and stated, We don't allow residents to have heating pads because of the risk of getting burned or any skin damage. The nurses were not aware of [Resident #107] uses a heating pad. 3) Observation on 02/17/2026 at 10:44 AM in Resident #29's room revealed a red puncture resistant container secured to the wall filled to capacity. (photo). On 02/17/2026 at 10:45 AM, the second-floor charge LPN was made aware and stated, It will be changed. During an interview on 02/19/2026 at 9:45 AM, the Director of Nursing stated: Staff are to change the sharps container when it is 3/4 full for safety of residents and staff. 4) Observation on 02/17/2026 at 9:58 AM revealed an unlocked door that locked from the inside in the second-floor south unit hallway that contained enteral and medical materials. On 02/17/2026 at 10:00 AM, The second-floor south unit charge LPN was notified and stated, This door is to be kept locked with a key for residents' safety.a resident could wander inside and get locked in. Record review of facility's policy and procedure titled, Free of Accident Hazards/Supervision/Devices dated: 1/2026 indicated: POLICY: It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. PROCEDURE: (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to properly position indwelling urinary catheter's tubing in a manner to promote free flow of urine for two (Resident #29 and Resident #76) of two sampled residents with an indwelling urinary catheter as evidenced by: 1)Resident # 29's indwelling urinary tubing observed extending down and up through pants with urine in the tubing. 2) Resident # 76's indwelling urinary catheter tubing observed coiled with urine in the tubing. This deficient practice prevented urine from freely flowing, increasing the risk for catheter-associated urinary tract infections and other serious medical issues.The findings included: Resident #76Observation on 02/17/2026 at 10:09 AM revealed Resident # 76 in bed, the indwelling urinary catheter tubing was looped and contained urine; there was less than 5 milliliters (mL) of urine in the drainage bag.On 02/17/2026 at 10:11 AM, the second-floor charge LPN was made aware and repositioned catheter tubing to allow the free flow of urine.Resident #76's clinical records revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses include but not limited to retention of Urine and Neuromuscular Dysfunction of Bladder. Record review of Resident #76's physician's order sheets revealed an order dated: 12/20/2025 to observe indwelling urinary catheter for placement, leakage, or dislodgement every shift.Record review of a care plan initiated 12/31/2025, revised on 01/12/26 revealed Resident#76 was at risk for infections related to urinary catheter indicated for Neurogenic bladder / Urinary Retention. The interventions included: Keep catheter below level of bladder but off the floor Keep catheter tubing free of kinks.Review of the Five-day Minimum Data Set reference dated 01/22/2026 revealed Resident #76 had no cognitive impairment, was dependent on toileting hygiene, had Septicemia, and an indwelling catheter.Record review of the facility's Infection Control Surveillance report for January 2026 revealed Resident #76 was receiving Cefuroxime Axetil 500 milligrams (mg) and Levofloxacin 500 mg antibiotics ordered on 1/18/26 for urinary infection. Resident #29Observation on 02/18/2026 at 11:28 AM revealed Resident #29 in room seated in wheelchair the indwelling urinary catheter tubing extended downward through the resident's pants and then secured upward on wheelchair, preventing urine from flowing freely (photo evidence). On 02/18/2026 at 11:30 AM, the second floor Charge Licensed Practical Nurse (LPN) was made aware and stated: The tubing will be adjusted to allow the free flow of urine.Record review of Resident #29's clinical records revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included Benign Prostatic Hyperplasia (BPH).Record review of a February 2026 physician orders sheet revealed: Resident #29 had orders dated: 2/5/26 for Suprapubic Catheter. Diagnosis: BPH and 2/10/26: Monitor Suprapubic catheter for placement, leakage, or dislodgement every shift. Record review of a care plan initiated 11/26/2025 and revised 12/08/2025 revealed Resident #29 at risk for infections related to suprapubic catheter indicated for Obstructive Uropathy with interventions including: Keep catheter below level of bladder but off the floor; keep catheter tubing free of kinks.Record review a Five-day Minimum Data Set reference dated 01/22/2026 indicated Resident #29 had no cognitive impairment, required substantial/ maximal assistance for shower/bathe, partial/moderate assistance for dressing, and had an Indwelling catheter. During an interview on 02/19/2026 9:43 AM, the Director of Nursing (DON) revealed the catheter tubing should be straight to prevent back flow of urine to prevent urinary tract infection (UTI). On 02/20/2026 at 7:56 AM, the Infection Preventionist stated, Staff are to ensure tubing is not kinked or coiled to prevent back flow of urine which could cause a UTI. Record review of the facility's Policies and Procedures: titled, Policies and Procedures Infection Control- Indwelling Catheter Care Date Issued: 1/2026 revealed POLICY: It is the policy of the facility to ensure that the residents receive care and services to prevent urinary tract infections in those residents with an indwelling catheter, in accordance with standards of practice.		

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NAME OF PROVIDER OR SUPPLIER The Lilac at Silver Palms		STREET ADDRESS, CITY, STATE, ZIP CODE 14601 NE 16th St North Miami, FL 33161	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review the facility failed to store food under sanitary condition and to ensure resident's food items were dated and labeled in the nourishment refrigerator on the Second Floor North Wing. This has the potential to affect 31 out of 35 residents who eat orally residing on the Second Floor North Wing out of 94 residents in the facility at the time of the survey. The findings included: Record review of the Use and Storage of Food Brought by Family or Visitors Policy and Procedure (revision date March 20223); Policy Statement-It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident; Policy Explanation and Compliance Guidelines: 2) All food items that are already prepared by the family or visitor brought in must be labeled with content and dated and a) The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. Observation of the nourishment refrigerator on the Second Floor North Wing used to store resident's foods on 2/17/26 at 8:41 AM revealed a lunch bag in the refrigerator without a name or date on it. Photographic evidence submitted. Interview and Observation with Staff A, Licensed Practical Nurse on 2/17/26 at 8:44 AM. She opened the lunch bag and it contained several food items. She stated, This belongs to a resident. The lunch bag should have a label on it and a date. Interview with the Director of Nursing on 2/17/26 at 9:49 AM. She confirmed that food items in the refrigerator and freezer for residents should be labeled and dated.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to collaborate and coordinate with hospice representative for one (#5) out of one sampled resident receiving hospice services as evidenced by: facility staff failed to obtain and keep nursing notes in the hospice folder for Resident#5 since December 2025 when Resident started with hospice. There were seven residents receiving hospice care residing in the facility at the time of survey. The findings included: On 02/19/26 at 1:00 PM Resident#5 was in bed with eyes closed and call light in reach. Oxygen was in progress at 2 Liters per minute, no apparent distress. Record review of Resident #5's clinical records revealed Resident #5 was admitted on [DATE] with diagnosis that included but not limited to: Encounter for Palliative Care and Heart Failure. Record review of a significant change in status minimum data set reference dated 12/12/25 indicated Resident #5 has moderate cognitive impairment and receiving hospice care. Record review of a care plan initiated on 11/06/25 and revised 11/07/25 revealed Resident #5 received hospice care with interventions that included: Hospice nurse to visit as per hospice schedule, days/times subject to change. Record review of a physician orders sheet revealed Resident #5 had orders dated 12/1/25 for hospice for evaluation and 12/3/25 to Admit to Hospice with diagnosis: Heart Failure. A record review of the Hospice Folder revealed a sign in sheet indicated nursing visited Resident#5 on 12/11/25, 1/15/26, 1/22/26, and 1/28/26 (photo), a Do Not Resuscitate form was dated and signed 11/12/25, admission Doctor's Orders form dated 12/2/25. No plan of care and no nursing notes were found in the folder. On 02/19/26 at 1:00 PM, the second floor Charge Licensed Practical Nurse (LPN) was asked about hospice visits and notes and stated, Resident #5 started with hospice December 2025. I verify that hospice staff comes by checking the book. I don't know how many times a week the hospice nurse visits or the last time. The surveyor asked why there were no hospice nursing notes readily available for review in Resident #5's medical records. The second floor Charge LPN replied, I have been calling asking for notes, but none have been sent. During an interview on 02/19/26 at 1:50 PM, the Director of Nursing (DON) stated: The hospice nurse visits once a week. Hospice staff are to sign, send notes and give report to the floor nurses. On 02/19/26 at 2:15 PM, the second floor Charge LPN entered the conference room and revealed to the surveyors that the hospice notes had just been emailed. The DON was also present and revealed this was not efficient. Record review of the Hospice Nursing Facility Agreement effective 07/23/2024 signed between facility and hospice company revealed Coordination of Care.(i) General. Facility shall participate in any meetings, when requested by Hospice, for the coordination of services provided to Hospice Patients. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day. Record review of the facility's policy and procedures titled, Hospice dated 1/2026 revealed Policy: It is the policy of the facility to provide collaborative care with Hospice providers to ensure that our resident's end of life preferences and choices are honored. Procedures:5. The designated interdisciplinary team member is responsible for the following: Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. Communicating with hospice representatives and other healthcare providers participating in the provision of care for terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to demonstrate effective plans of action were implemented to correctly identify repeated deficient practices in the problem areas of F880 Infection Prevention & Control, F689 Free of Accident hazards/Supervision/Devices, and F761Medication Storage. These deficient practices have the potential to affect 168 residents residing in the facility at the time of the survey. The findings included: Record review of the facility's Quality Assurance and Performance Improvement policy and procedure dated 1/2026 indicated: These policies are intended to ensure the facility develops a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.Policy: The facility, will develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Review of the facility's survey history revealed, during a recertification survey with exit dated January 30, 2025, F880 Infection Prevention & Control, F689 Free of Accident hazards/Supervision/Devices, and F761Medication Storage were cited.Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets revealed: The facility had a QAA Committee meeting monthly. Attendees included: Administrator, Medical Director, Director of Nursing (DON) and other department heads.Interview with the Administrator on 02/20/2026 at 3:15 PM revealed the QAPI (Quality Assurance and Performance Improvement) meetings are held each month or as needed. The members include: The Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing/ Infection Preventionist, Maintenance Director, Housekeeping/Laundry Supervisor, Social Services Director, Activity Director, Food Service Manager, Business Office Manager, Admissions Coordinator, Medical Records, Registered Dietitian, Pharmacist consultant, Unit Managers and Certified Nursing Assistants. The purpose of the QAPI is to identify and review interventions to meet all the need of residents and ensure regulations are being followed; evaluate and revise interventions as needed. We monitor the progress of our goals by receiving input from staff, family, residents and vendors as well as doing rounds daily. All issues are considered a priority. We have some plans of improvement that remain ongoing.'		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow infection control protocol when storing medical equipment for two (#38, #46) out of two sampled residents as evidenced by: 1) Observation of an incentive spirometer not stored in a dated plastic bag. 2) Observation of an enteral syringe dated 2/16/26 stored at the bedside of Resident#46 for two days. There were 94 residents residing in the facility at the time of survey. The findings included: Resident #38 Observation on 02/17/2026 at 8:25 AM revealed an uncovered incentive spirometer stored at Resident #38's bedside. Record review Resident#38's clinical records indicated the resident was admitted on [DATE] with diagnosis that included but not limited to: Cerebral Ischemia. Record review of a Modification of interim payment minimum data set (MDS) reference dated 12/22/25 revealed Resident #38 had no cognitive impairment and received respiratory therapy for seven days. Record review of a care plan initiated: 12/13/2025 revised: 12/15/2025 revealed Resident #38 was at risk for respiratory complications secondary to history of Pulmonary Embolism with interventions that included but not limited to: Observe for signs and symptoms of respiratory complication. Notify Medical Doctor if abnormal findings. On 02/18/2026 at 8:23 AM Resident #38 revealed the incentive spirometer is used daily. On 02/18/2026 at 10:34 AM the Second-Floor Charge Licensed Practical Nurse (LPN) revealed the respiratory care supplies are to be stored in a plastic bag and the bags are dated for infection control purposes. On 02/18/2026 at 10:35 AM Staff B, LPN was made aware of the identified concern and stated, The order for an incentive spirometer was discontinued. An interview on 02/19/2026 at 10:00 AM with the Director of Nursing (DON) revealed Respiratory care items are kept in a plastic bag, dated and changed every seven days for infection control. Record review of the facility's Policies and Procedures: titled, Respiratory/Tracheostomy Care and Suctioning Date Issued: 1/2026 revealed POLICY: The intent of this policy is that each resident receives necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan and resident's choice. PROCEDURE: The facility will ensure that a resident, who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' c goals and preferences Resident#46 Observation on 02/17/2026 at 10:08 AM revealed Resident#46 was in bed eyes closed and an enteral syringe dated 2/16/26 was on the nightstand. On 02/18/2026 at 8:24 AM Resident#46 was in bed eyes closed and an enteral syringe dated 2/16/26 was observed on the nightstand. Review of Resident#46's clinical records revealed the resident was admitted to the facility on [DATE] and readmitted [DATE]. Clinical diagnoses include Encounter for attention to Gastronomy. Review of the Quarterly Minimum Data Set, dated [DATE] indicated the resident is severely impaired cognitively, dependent on Activities of Daily Living and has a feeding tube. Record review of a care plan initiated: 02/03/2026 revised: 02/17/2026 revealed Resident #46 required an enteral feeding tube only for hydration needs with interventions that included but not limited to: Administration of flushes as ordered and check patency and placement of tube daily and before administering feedings and or meds. Record review of a physician's order sheet revealed Resident #46 had orders dated: 2/2/2026 for water flush 120 milliliters (mL) every shift via PEG for tube patency every shift related to Hemiplegia and hemiparesis following cerebral infarction affection left non dominant side and 2/13/26 for Valproic Acid Oral Solution 500 milligrams per 10 mL one time a day for Mood disorder via PEG. Record review of the February 2026 Medication Administration Record revealed signatures indicating flushes and Valproic Acid Oral Solution were administered daily via PEG to Resident #46. On 02/18/2026 at 8:54 AM Staff B, LPN revealed Resident #46 receives medications and water flushes via Percutaneous Endoscopic Gastrostomy (PEG) and stated, The overnight shift is responsible to change the syringe, and I check it before I administer medications. An interview on 02/19/2026 at 9:47 AM with the DON revealed enteral syringes are not to be used more (continued on next page)		

Department of Health & Human Services
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	than 24 hours for infection control and the night shift nurses are expected to change the syringes each night shift. Record review of the facility's Policies and Procedures: titled, Policies and Procedures: Enteral Feeding Medication Administration Date Issued: 1/2026 revealed POLICY: It is the policy of the facility to provide appropriate medication administration to residents who receive their medications via an enteral feeding tube to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance to State and Federal regulation. Record review of the facility's Policies and Procedures: titled, Policies and Procedures: Infection Prevention and Control and Surveillance Program Date Issued: 1/2026 revealed POLICY: It is the policy of the facility to ensure that the Infection Control Program is designed to prevent, identify, report, investigate, and control the spread of infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement; provide a safe, sanitary and comfortable environment; and to help prevent the development and transmission of disease and infection, in accordance with State and Federal Regulations, and national guidelines.		