

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: 676220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Granite Mesa Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Max Copeland Dr Marble Falls, TX 78654	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure they were adequately equipped to allow residents to call for staff assistance through a communication system which relays relayed the call directly to a staff member or a centralized staff work area from each resident's bedside for 5 of 10 residents (Residents # 13, # 31, # 47, # 48 and # 67) reviewed for call lights. The facility failed to ensure Residents # 13, # 31, # 47, # 48 and # 67's call lights were within reach of the residents. These failures could place residents at risk of not being able to call for staff assistance to meet care needs or at risk of injury, pain, hospitalization, and a diminished quality of life. Findings included: 1. Record review of Resident #13's face sheet, dated 12/30/2025, revealed she was a 68-year-old female who was admitted to the facility on [DATE]. Resident #13's had diagnoses which included anxiety (feeling uneasiness or worry), dementia (memory, thinking, difficulty), Schizoaffective Disorder, Bipolar Type (including bouts of hypomania or mania (Increased energy, reduces need for sleep) and hypomania (a milder form of mania) or and sometimes major depression and), hypertension (high blood pressure), (mood disturbances, anemia (not enough healthy red blood cells), muscle wasting and muscle weakness. Record review of Resident #13's Quarterly MDS, dated [DATE], revealed Resident #13 had a BIMS score of 12, which indicated moderate cognitive impairment, suggesting that the individual may need additional support and monitoring. During an observation on 12/30/2025 at 9:51 a.m., revealed Resident #13 was asleep in her wheelchair, located to the left of the bed. The call light was on the far-right side of the bed, not within reach of residents. 2. Record review of Resident #31's face sheet, dated 12/31/2025, revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #31's had diagnoses which included unspecified dementia (memory, thinking, difficulty), muscle wasting, muscle weakness, Osteoarthritis (progressive deterioration of the articular cartilage in the right hip), and abnormalities with gait and mobility. Record review of Resident #31's Quarterly MDS, dated [DATE], revealed Resident #31 had a BIMS score of 5, indicating which indicated moderate cognitive impairment, suggesting that the individual may have difficulties with memory and thinking skills. During an interview and observation with Resident #31 on 12/29/2025 at 10:36 a.m., he said he was waiting for someone to come help him. He said staff did not answer his call light. Resident #31 was lying on his bed with his legs hanging halfway off the bed. His call light was on the floor between the wheelchair tire and the seat of the wheelchair. 3. Record review of Resident #47's face sheet, dated 12/30/2025, revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #47's had diagnoses which included Alzheimer's Disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior.), Need for assistance with personal care, Pain in right wrist and muscle wasting and atrophy. Record review of Resident #47's Quarterly MDS, dated [DATE], revealed Resident #47's BIMS score was unable to be calculated. During an interview and observation with Resident #47 on 12/29/2025 at 9:24 a.m., revealed the resident was lying in bed awake. Resident # 47 could not locate the call light button. Resident #47 stated she did not use the call light button often. Observation noted the call light button was on the right side of the bed on the floor, out of reach of Resident # 47. 4. Record review of (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #48's face sheet, dated 12/31/2025, revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #48's had diagnoses which included unspecified dementia (memory, thinking, difficulty), Cognitive Communication deficit, anxiety disorder (feeling of uneasiness or worry), muscle weakness, Lack of coordination, Anorexia Nervosa, (an eating disorder). Unspecified (eating disorder). Record review of Resident #48's Quarterly MDS, dated [DATE], revealed Resident #48 had a BIMS score of 04, which indicated severe cognitive impairment, suggesting that the individual may require significant assistance with daily activities and cognitive tasks. During an interview and observation with Resident #48 on 12/29/2025 at 12:32 p.m., revealed the resident was awake and lying in bed. Resident #48 stated she often used her call light button when she needed to be changed. A flat call light pad was observed to be located out of the resident's reach, on the right side of the bed on the floor.5. Record review of Resident #67's face sheet, dated 12/31/2025, revealed he was a 62- year-old female who was admitted to the facility on [DATE]. Resident #67's had diagnoses which included Alcoholic Cirrhosis of the liver (toxic fat to build up in the liver), low platelet count in the blood, Blindness left eye category 5 (severe visual impairment), dementia (memory, thinking, difficulty), muscle weakness, pneumonia (an infection that inflames the air sacs in one or both lungs.), Anxiety Disorder (feeling of uneasiness or worry) and unsteadiness on feet.Record review of Resident #67's Quarterly MDS, dated [DATE], revealed Resident #67 had a BIMS score of 15, indicating which indicated intact cognitive Response.During an interview with Resident #67 on 12/30/2025 at 9:29 a.m., revealed that the resident was sitting in her wheelchair on the right side of her bed. The resident's call light button was hanging off the left side of the bed, out of reach of the resident. During an interview with RA on 12/31/2025 at 9:47 a.m., revealed that she had been trained on resident rights. She said the policy for call light placement was that it must be within reach of the resident and if a staff member was working with a resident, they were responsible for making sure the call light was within the resident's reach. She stated if they were unable to push the button, they may require a special, larger call light button for that resident. She stated that some residents preferred to have the call light out of sight. She stated if a call light was not within reach of a resident, they may not be able to call for help. During an interview with the ADON on 12/31/2025 at 10:00 a.m., revealed that she had been trained on resident rights. She said that staff were in-serviced on the policy regarding call light button locations and response times. She stated all the staff were responsible for locating the call light within the residents' reach. She stated if a resident could not reach the call light, they may have an accident or a fall.During an interview with CNA D on 12/31/2025 at 10:19 a.m., she stated that she has been trained on resident rights and call light location in the last in-service training. She stated all of us were responsible for monitoring and making sure the call light button was within reach of the residents. The call light should always be within reach of the resident for the safety of the resident. If the call light was not within reach the resident could fall. During an interview with the ADM on 12/31/2025 at 11:54 a.m., he revealed that all the staff were responsible for making sure the call light was within the resident's reach. The call light should be within reach of the resident following care. The ADM stated it depended on the resident as to what could happen if the call light was not within the reach of the resident. He stated, if the patient was bed bound and they couldn't use the call light, the staff may not be able to get to them in time. The ADM stated that some of the residents were mobile and if the call light buttons were not nearby, they could get up and get it by themselves. It is the nursing staff's responsibility to make sure the call lights are within reach of each resident. During an interview with the DON on 12/31/2025 at 11:37 a.m., revealed that he had been trained in resident rights and making sure the environment was safe. He stated that every signal person who walked by or entered a resident room was responsible for making sure the residents call light button was within the resident reach. Record review of In-services reflected the following:9/15/2025 In-service Training Topic: Ice water/ Call lights12/17/2025 In-service Training Topics: Call lights, Rounding.Record review of the facility's undated Policy/ Procedure- Nursing Clinical- Policy reflected the following: Subject: Call lightsPolicy: (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it is the policy of this facility to provide the residents with a means of communication with nursing staff.Procedure:5. Leave the resident comfortable. Place the call device within residents reach before leaving the room. If the call light/ bell is defective, immediately report this information to the unit supervisor.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 3 of 3 residents (Resident #1, Resident #26 and Resident #70) reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #1's admission MDS, dated [DATE], accurately reflected his smoking status. 2. The facility failed to ensure Resident #26's admission MDS, dated [DATE], accurately reflected her smoking status. 3. The facility failed to ensure Resident #70's admission MDS, dated [DATE], accurately reflected her smoking status. These failures could place residents at risk of inadequate supervision due to an inaccurate assessment of smoking status. Findings include: 1. Record review of Resident #1's face sheet, dated 12/30/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included peripheral vascular disease (abnormal narrowing of arteries), adult failure to thrive (a progressive overall decline), localized swelling, tinea unguium (fungal nail infection), muscle weakness, lack of coordination, and abnormalities of gait and mobility. Record review of Resident #1's admission MDS, dated [DATE], revealed Resident #1 had a BIMS score of 14, which indicated intake cognitive response. Resident #1's MDS current tobacco use was marked as no. Record review of Resident #1's care plan, dated 12/02/2025, revealed Resident #1 has the potential for injury related to smoking. Resident #1's goal was Will be compliant with individual smoking plan until next review. Will have no injuries related to smoking. The interventions were Complete smoking assessment as needed. Explain smoking policy. Maintain smoking materials at nurses' station or other designated area. Observe smoking while in designated area. Report non-compliance or unsafe smoking habits to MD and responsible party. Staff will provide a copy of the smoking policy on admission and as the policy is revised. Record review of Resident #1's smoking assessment, dated 11/21/2025, revealed resident don't smoke. 2. Record review of Resident #26's face sheet, dated 12/30/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included chronic obstructive pulmonary disease (chronic progressive lung disease), protein-calorie malnutrition (inadequate intake of both protein and calories), heart disease, fall, muscle wasting, cannabis dependency, metabolic encephalopathy (brain disease), and lack of coordination. Record review of Resident #26's admission MDS, dated [DATE], revealed Resident #26 had a BIMS of 10, which indicated moderate impairment. The MDS also revealed current tobacco use was not on the MDS. Record review of Resident #26's care plan, dated 07/05/2025, revealed Resident #26 has the potential for injury related to smoking. Resident #26's goal was Will be compliant with individual smoking plan until next review. Will have no injuries related to smoking. The interventions were Complete smoking assessment as needed. Explain smoking policy. Maintain smoking materials at nurses' station or other designated area. Observe smoking while in designated area. Report non-compliance or unsafe smoking habits to MD and responsible party. Resident #26 required a smoking apron. Utilize smoking apron during smoking activities. Record review of Resident #26's Smoking Assessment, dated 12/08/2025, revealed Resident #26 smoked three times a day. Resident #26 required supervision and a smoking apron. 3. Record review of Resident #70's face sheet, dated 12/30/2025, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #70 had diagnoses which included lack of coordination, hypertension (high blood pressure), muscle wasting, muscle weakness, type 2 diabetes mellitus with diabetic neuropathy (nerve damage due to diabetes), tinea unguium (fungal nail infection), heart disease, acquired absence of unspecified leg below knee, and malaise (feeling of general discomfort). Record review of Resident #70's admission MDS, dated [DATE], revealed Resident #70 had a BIMS of 99, which reflected the resident was unable to complete the interview. The MDS also revealed current tobacco use was checked NO. Record review of Resident #70's care plan, dated 12/15/2025, revealed Resident #70 has the potential for injury related to smoking. Resident #70's goal was Will be (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	compliant with individual smoking plan until next review. Will have no injuries related to smoking. The interventions were Complete smoking assessment as needed. Educate resident on smoking practices. Explain smoking policy. Maintain smoking materials at nurses' station or other designated area. Observe smoking while in designated area. Report non-compliance or unsafe smoking habits to MD and responsible party. Record review of Resident #70's Smoking Assessment, dated 12/15/2025, revealed Resident #70 smoked three times a day. The smoking assessment did not indicate the resident needed to be supervised. During an observation of smoking on 12/30/2025 at 2:00pm revealed resident #1 and Resident #26 were outside with staff smoking. Both residents had smoking aprons on. During an interview with Resident #1 on 12/30/2025 at 2:05p.m., revealed that he goes out to smoke with staff three times a day. He said that all residents who smoke wear the smoking apron and that the staff watch them and are with them the whole time. During an interview with Resident #26 on 12/30/2025 at 2:13p.m., revealed that she smokes three times a day. She said staff are always made them wear a smoking apron. She said they disposed of the cigarettes in the ash tray and made sure not to throw the cigarette butts on the ground. During an interview with the ADM on 12/30/2025 at 3:55 p.m., he said he had not been trained on the MDS. He said the MDSN was responsible for ensuring the MDS was done. He said general information for the residents' care and history would be on the MDS. He said the resident/family requested smoking upon admission. He said if the resident's smoking status was not on the MDS the resident could miss smoking times. He said he did not know who monitored the MDS. He said the resident's smoking status, not being on the resident's MDS, was a mistake. During an interview with the MDSN on 12/30/2025 at 4:10 p.m., she said she had been trained on the MDS. She said she was responsible for completing the MDS. She said every fact about the resident and head to toe assessments went on the MDS. She said the MDS was updated when there was a significant change in status and quarterly. She said the DON would tell her what residents smoked. She said a resident's smoking status went on the comprehensive MDS but did not go on the quarterly MDS. She said if the resident's smoking status was on the MDS, there would not be communication to other staff about the resident smoking. She said the MDS was not monitored. She said the resident's smoking status would not be on the admission MDS if the resident's smoking assessment was done after the admission assessment. During an interview with the DON on 12/30/2025 at 4:30 p.m., revealed he had not been trained on the MDS. He said the MDSN was responsible for doing the MDS. He said everything that had to do with the resident's care profile, diagnoses, treatments, and the resident's ADLs. He said he did not know if the resident's smoking status went on the MDS. He also said he did not know how the resident's smoking status on the MDS would affect the resident's care. He said the resident's smoking status was missed on admission. Record review of the Smoking Residents list provided on 12/29/2025 revealed Resident #1, Resident #26, and Resident #70 were all smokers. Record review of Resident Assessment and Associated Processes Policy, dated 4/2025, revealed It is the policy of this facility that resident will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessments of each resident, and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified. Comprehensive Assessment: includes the completion of the MDS (Minimum Data Set) as well as the CAA (Care Area Assessment) process, followed by development and/or review of the comprehensive care plan. Comprehensive MDS assessments include Admission, Annual, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment. An accurate Comprehensive Assessment will be made of the resident's needs, strengths, goals, life history, and preferences, using the RAI (Resident Assessment Instrument).		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a resident or family group with private space, and take responsible steps, with the approval of the group, to make residents and family members aware of upcoming meeting in a timely manner ensure the confidentiality offer Residents participating in Resident Council meetings in dining room [ROOM NUMBER] of 1 resident council meetings reviewed for resident rights. The facility failed to ensure that Staff members did not enter the dining room uninvited during the meeting, resident council meetings exposing residents to loss of privacy. This failure could affect place residents by placing them at risk for loss of privacy and dignity. The Findings included: Observation of the resident council meeting on 12/29/2024 at 2:30 PM, revealed that 2 staff members, (Hospitality Aide and Dietary Aide) entered the dining room entry doors during the resident council meeting. During an interview on 12/31/2025 at 9:08 AM, revealed that the Activities Director had been trained in Resident Rights and in Abuse Neglect and Exploitation. The Activities Director has received training through Relias Training online and in- services on these subjects as well. She stated residents have had the right to make complaints and to be able to speak privately. She stated that a sign should be posted on each of the doors to the dining room in order that uninvited staff did not enter when the meeting was going on. She stated that no sign was posted prior to the Resident Council meeting on 12/29/2025 because the meeting was changed from 12/31/2025 to 12/29/2025 and it was an oversight. The Activities Director stated she was responsible for ensuring residents have had a private place to meet. The Activities Director stated the Resident Council President and the Resident council Secretary have had the right to run their meeting without staff present and that only invited staff members were to be present. During an Interview with the Resident Council President on 12/29/2025 at 3:01 PM, revealed that only staff members that had been were invited to the meetings were allowed to enter the Resident Council meeting. Resident Council President stated, the Activities Director had an ongoing invitation to their meeting, and she did not know of any other staff who were invited. She stated that the Activities Director has had an ongoing invitation to their meeting, and she does did not know of any other staff that had been invited. During an interview with the Resident Council Secretary on 12/29/2025 at 3:07 PM, revealed the meetings are always held in the dining room. The Secretary stated that she has invited the Activities Director to the Council Meetings for the purpose of taking notes. Record review of the facility's, undated, Resident Council meeting policy for Granite Mesa Health Center, reflected the following: Policy: It is the policy of this facility to: 1. Provide a forum through which constructive suggestions, ideas and concerns may be offered and projects initiated for the mutual benefit of the institution and the residents of the facility. Procedures: 2/ Invited guest speakers: such as the Director of Nursing Services. or even persons from outside agencies may be invited to speak for resident's benefit. Record review of the facility's policy on Resident Rights reflected the following: Dignity and respect Be treated with dignity, courtesy, consideration and respect. Freedom of choice You have the right to: Make your own choices regarding personal affairs, care and services. Privacy and confidentiality You have the right to: Privacy, including privacy during visits and telephone calls and while attending to personal needs.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment were referred for 1 of 2 residents (Resident #4 and Resident #99) reviewed for PASSAR. The facility failed to ensure Resident #99's level 1 PASSAR accurately reflected her Mental Illness diagnosis. The facility failed to ensure Resident #4 received a new level 1 PASSAR screening after having a new diagnosis that would reflect a Mental Illness diagnosis. This failure could place residents at risk of loss of specialized services for their Mental Illness, Developmental Disability and Intellectual Disability. Findings include: Record review of Resident #4's face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included Bipolar Disorder (serious mental illness causing extreme mood swings, from manic highs to depressive lows), Acute Embolism and Thrombosis of unspecified Deep Veins (serious condition where a blood clot forms in a deep vein), and Type 2 Diabetes (chronic condition where the body either doesn't make enough insulin or doesn't use insulin effectively leading to high blood sugar levels, as sugar can't enter cells for energy). Record review of Resident #4's quarterly MDS, dated [DATE], revealed a diagnosis which included bipolar disorder and a BIMS of 06, which indicate impaired cognitive function. Record review of Resident #4's care plan revealed the resident could be resistive to care related to bipolar disorder, dated 01/17/2024. Record review of Resident #4's Level 1 PASSAR screening, dated 07/17/2013, revealed there was no evidence of any Mental Illness, Intellectual Disability or Developmental Disabilities. Record Review of Resident #99's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #99 had diagnoses which included Muscle Wasting and Atrophy (thinning and loss of muscle tissue, causing decreased mass and strength), Major Depressive Disorder (a serious mood disorder causing persistent sadness, loss of interest, and impacts feelings, thinking, and behavior, leading to impaired daily functioning, with causes involving genetic, environmental, and biological factors), and Generalized Anxiety Disorder (a mental health condition marked by persistent, excessive, and uncontrollable worry about everyday things). Record review of Resident #99's quarterly MDS, dated [DATE], revealed diagnoses of anxiety disorder and Depression. The MDS also revealed no BIMS score. Record review of Resident #99's care plan revealed the resident had anxiety disorder and was receiving anxiety medication, dated 08/29/2023. It also revealed residents were receiving antidepressant medication related to a diagnosis of depression, dated 08/29/2023. Record review of Resident #99's level 1 PASSAR screening, dated 08/21/2023, revealed no evidence of Mental Illness, Intellectual Disability and/or Intellectual Disability. An interview on 12/31/2025 at 1:52 PM with MDSC revealed that MDSC had been employed at the facility for 8 years. The MDSC said they received training on PASSAR which included steps to take when a resident entered a facility which included how to enter the PL1 when it was received from the hospital, the facility would have 14 days to do their evaluation on the resident and move forward based on their decision. The MDSC stated the last time they received PASSAR training was in 2025. The MDSC stated the policy for PASSAR was to complete a PASSAR screen on every admission and the MDSC was responsible for the screening and ensured the screening was done correctly. If a resident was identified as having newly evident or possible MD, ID or a related condition after admission, the facility's process for referring the resident to the appropriate state designated authority would be to do the 1312 form, have the physician sign it, and do a new PASSAR and send it through according to the MDSC. The MDSC stated Resident #4's diagnosis of bipolar disorder diagnosed on [DATE] would indicate a positive level 1 PASSAR. The MDSC stated a new PASSAR should have been completed since the diagnosis came after the previous PASSAR screening. The MDSC stated this could negatively affect the residents by not getting the (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services they needed. The MDSC also stated a PASSAR should be done on admission and if they received services by psychiatry at the facility. The MDSC stated a resident could have a negative level 1 if there was a positive diagnosis if dementia overrode the diagnosis which was not the case for Resident #99. The MDSC stated Resident #99's diagnosis of Major Depressive Disorder would indicate a positive level 1 PASSAR. The MDSC stated Resident #99's PASSAR was negative on 08/22/2023 because a Level 1 PASSAR document was not sent off yet. The MDSC stated the PASSAR being incorrect could negatively affect Resident #99 by not receiving designated services for her diagnosis. An interview on 12/31/2025 at 2:08 PM with the DON revealed the DON had been employed at the facility for 4 months and 3 days. The DON stated he received training on PASSAR which covered there was certain diagnosis that made a person PASSAR qualified. The training also included interviewing residents with local authorities and would receive special benefits if the PASSAR was positive or not. The training included developmental diagnosis, and mental diagnosis would qualify. The DON stated he had the training in August 2025. The DON stated the policy for PASSAR was it should be done upon admission and/or diagnosis change by the MDSC who also should verify if it was correct. An interview on 12/31/2025 at 3:13 PM with the ADM revealed the ADM had been employed at the facility since October 2023 and received training on PASSAR. The training covered how staff completed a PASSAR for all residents. The ADM stated the policy for PASRR said the PASSAR screenings were completed according to regulation. The ADM stated the MDSC was responsible for completing the PASSARs or ensuring the facility had a PASSAR and should be completed upon admission and/or change of diagnosis. The ADM stated Resident #4's diagnosis of bipolar disorder would indicate a positive level 1 PASSAR. The ADM also stated a new PASSAR should have been completed since the diagnosis was after the previous PASSAR screening. The ADM stated it could negatively affect her if it was incorrect by certain services under PASSAR may have been missed. The ADM stated a resident could have a negative level 1 PASSAR if there was a positive diagnosis if there was a misunderstanding. The ADM stated Resident #99's diagnosis of Major Depressive Disorder which was diagnosed on [DATE] should have indicated a positive level 1 PASSAR. The ADM stated he was unsure why the PASSAR was negative on 08/22/2023. This inefficiency could affect the residents negatively by resulting in missing services. Record review of an undated document provided by the facility titled Nursing Facilities Responsibilities Related to PASSAR which include the following steps:1. If an individual seeks admission to a facility, they must have completed PL1 before admitting to the facility. 2. If PL1 identifies MI, ID or DD then a LIDDA or LMHA completes and enters a PE.3. Withing 7 calendar days the facility must review recommended list of NF/LIDDA/LMHA specialized services and certify in the LTC online portal whether the individual needs can be met at the facility.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient fluid intake is offered to maintain proper hydration and health provide hydration care and services to each resident, consistent with the resident's comprehensive assessment for 2 of 10 residents (Residents #10 and # 47) reviewed for hydration .The facility failed to follow the facility policy and did not provide adequate hydration for 2 residents. Residents #10 and #47. These failures could place residents at risk of not having hydration needs met and/or becoming dehydrated.Findings include: 1. Record review of Resident #10's face sheet, dated 12/31/2025, revealed a 92 -year-old female originally admitted on [DATE]. A Resident #10's relevant diagnoses included Alzheimer's Disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior, and is the most common cause of dementia.), Muscle wasting and atrophy, Muscle weakness, Anxiety Disorder (feeling of uneasiness or worry), Need for assistance with personal care and hypertension (high blood pressure).Record review of Resident # 10's [NAME] MDS, submitted 11/28/2025, revealed a BIMS score of 99, indicating which indicated the resident was unable to complete the interview. MDS revealed Resident # 10 has functional limitation in range of motion in the lower extremities and use of a mobility device (wheelchair) is needed.Record review of Resident # 10's care plan dated 1/25/2025 reflected:Diagnosis of gout increases her risk of joint pain, with a goal to be free of complications related to gout. Interventions include encouraging adequate nutrition and hydration. During an observation and interview on 12/29/2025 at 9:18 a.m., revealed Resident #10 was lying in bed awake. Resident #10 stated she could see her water across the room, but she could not reach it. The water cup was located over 5' away from the resident's bed. Resident #10 stated, they gave me drinks with my breakfast.2. Record review of Resident #47's face sheet, dated 12/30/2025, revealed a 100 -year-old female originally admitted on [DATE]. A Resident #47's relevant diagnoses included Alzheimer's Disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior, and is the most common cause of dementia.), Muscle wasting and atrophy, Muscle weakness, Anxiety Disorder (feeling of uneasiness or worry), Need for assistance with personal care and hypertension (high blood pressure). Record review of Resident # 47's [NAME] MDS, submitted 11/18/2025, revealed a BIMS score of 00, indicating which indicated a severe problem with thinking and memory. Review of Section GG- Functional Abilities reflected. The resident needed set up or clean-up assistance while eating food and/or liquid once meal was placed before the resident. During an observation on 12/29/2025 at 10:54 a.m., revealed Resident # 47 was lying in bed, asleep with a blanket covering her from chin to toe. There was no hydration was observed within the residents' reach. Attempted interview with Resident # 47 but the resident was unable to respond because she was asleep. During an interview with the Restorative Nursing Assistant on 12/31/2025 at 9:47 a.m., revealed that she had been trained on resident rights. She said fluids should be placed within reach of the resident and if a staff member was working with a resident, they were responsible for making sure the call light and fluids were within the resident's reach. She stated we the staff lay eyes on them constantly. If someone sees it, we the staff fix it. She stated that the facility has had 1 hospitality Aid who helped fill water cups for residents. She stated, if the residents don't didn't get adequate hydration, they might need to get evaluated by the nurse and some residents may need IV hydration. During an interview with the ADON on 12/31/2025 at 10:00 a.m., revealed that she had been trained on resident rights. She said that staff were in-serviced in Residents Rights, hydration and call lights. She stated each resident should have fluids within reach of a resident and every time I went into the room, I the ADON stated she checked that hydration was near a resident. ADON stated, she did not know why 2 two residents were not provided with fluid within reach. She stated it must have been between visits from the hospitality Aid. She stated all staff were responsible for ensuring residents always have fluid within reach. She stated if the resident was not provided with adequate (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hydration it could lead to dehydration, UTIs or acute illness. During an interview with CNA on 12/31/2025 at 10:19 a.m., she stated that she has been trained on resident rights and call light location in the last in-service training. She stated it was the expectation of the facility that each resident should always have fluids within reach, on the bedside table. She stated that residents should be checked for fluids during rounds. She stated, residents could get dehydrated if they did not have fluids available to them. She did not know why 2 two residents didn't have fluids available. During an interview with the ADM on 12/31/2025 at 11:54 a.m., he revealed that the nursing staff were responsible for monitoring that fluids were provided for residents, and that the fluids were within reach of the residents. He stated We have room rounds in the morning, and we always check to be sure all residents have fluids nearby. The Hospitality aid is the primary person responsible for making sure all residents have hydration nearby. He stated a resident could become dehydrated if they did not get enough water. He stated he did not know why 2 two residents did not have fluids near their beds. Record review of In-services: On 9/15/2025 In-service Training was completed for staff on Topics: Ice water/ Call lights. Record review of the facility's, undated, policy titled Policy & Procedure Subject: Hydration. Policy: It is the policy at this facility that each resident will be provided with sufficient fluid intake to maintain proper hydration and health. Procedures: 2. Fluids will be offered/provided between meals for the dependent residents, unless contraindicated. 4. Additional beverages or alternatives (popsicles, gelatin, and other similar non-liquid foods) will be distributed throughout the day, depending on physician orders and resident preference. Resident [NAME] request additional fluids and receive them, if not contraindicated.		

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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 observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for Food safety and Nutrition Services. The facility failed to ensure food safety by not performing proper hand hygiene when preparing puree foods. This failure could place residents at risk for food-borne illnesses. Findings include: Observation of DA A preparing puree food on 12/29/2025 at 10:29 a.m. revealed that DA A did not wash her hands before starting the puree process for the meatballs. She gave the puree machine to the dishwasher and went to wash her hands. She put meatballs into steamer. She then got a rag and wiped the counter down, got the puree machine. She put the noodles in the puree machine without washing her hands. She gave the puree machine back to dishwasher, got foil wrapped noodles put the noodles in the steamer, got water to add to steamer, and got a rag to wipe down the counter. She did not wash hands between any of the tasks she completed. She got the broccoli and put it in the puree machine, got the spatula for the broccoli, and put foil over the pureed broccoli and got a rag to wipe down the counter. She did not wash her hands between any of the tasks she completed. During an interview with the ADM on 12/30/2025 at 3:55 p.m., he said he was trained on infection control. He said the policy for hand hygiene was that all staff were to follow the proper hand hygiene protocol. He said staff were to wash their hands before and after providing care to a resident or after touching something soiled or dirty. He said if proper hand hygiene was not followed it could cause infection control issues, and the residents could get sick. He said the ADM and management monitored to ensure staff were washing their hands. He said the ADM and management monitored through yearly skills checks, and random in-services throughout the year. During an interview with DA A on 12/31/2025 at 8:31 a.m., she said she was trained on infection control. She said the policy was to wash your hands between each task. She said all staff were responsible for washing their hands. She said if staff did not wash their hands, it could cause infections to spread to the residents. She said the management and the ADM monitored it to ensure staff were washing their hands. She said she did not know why she did not wash her hands between each task. During an interview with the DM on 12/31/2025 at 9:00 a.m., she said she was trained on infection control. She said the policy was to wash your hands any time staff went into the kitchen. She said all staff were responsible for washing their hands. She said if staff did not wash their hands, it could cause the facility to have to throw food away or the residents could get sick. She said the Dietary manager monitored it to ensure staff were washing their hands. She said she was not sure why DA A did not wash her hands. She said DA A needed more training. Record review of the facility's, undated, Infection Control Policy/Procedure- Dietary Department revealed It is the policy of this facility to comply with all state, federal and local infection control standards and regulations concerning: Personnel requirements Preparation and service Food storage Equipment, care and storage Isolation procedures and techniques Follow all hand washing policies. Record review of the facility's Policy/Procedure Hand Hygiene, dated 12/2023, revealed It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene, which is one of the most effective measures to prevent the spread of infection, based on accepted standards. Residents, family, and visitors will be encouraged to practice hand hygiene. Procedure 1. Wash hands with soap and water for the following situations: a. When hands are visibly soiled. 2. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water before and after eating or handling food. Washing Hands a. Vigorously lather hands with soap and rub them together, creating friction on all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature. Hot water is unnecessarily rough on hands. b. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink. c. Dry hands thoroughly (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with paper towels and then turn off faucets with a clean, dry paper towel.d. Discard towels into trash.e. Use lotions throughout the day to protect the integrity of the skin.Using Alcohol-Based Hand Rubsa. Apply generous amounts of product to palm of hand and rub hands together.b. Cover all surfaces of hands and fingers until hands are dry.c. Follow manufacturers' directions for volume of product to use.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for complete and accurate medical records. The facility failed to ensure Resident #1's smoking assessments, dated 11/21/2025, accurately reflected his smoking status. Resident #1's smoking assessment said, resident don't smoke. This failure could place residents at risk of not having the right to smoke or not having adequate supervision while smoking. Findings include: Record review of Resident #1's face sheet, dated 12/30/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included peripheral vascular disease (abnormal narrowing of arteries), adult failure to thrive (a progressive overall decline), localized swelling, tinea unguium (fungal nail infection), muscle weakness, lack of coordination, and abnormalities of gait and mobility. Record review of Resident #1's admission MDS, dated [DATE], revealed Resident #1 had a BIMS score of 14, which indicated intake cognitive response. Resident #1's MDS current tobacco use was marked as no. Record review of Resident #1's care plan, dated 12/02/2025, revealed Resident #1 has the potential for injury related to smoking. Resident #1's goal was Will be compliant with individual smoking plan until next review. Will have no injuries related to smoking. The interventions were Complete smoking assessment as needed. Explain smoking policy. Maintain smoking materials at nurses' station or other designated area. Observe smoking while in designated area. Report non-compliance or unsafe smoking habits to MD and responsible party. Staff will provide a copy of the smoking policy on admission and as the policy is revised. Record review of Resident #1's smoking assessment, dated 11/21/2025, revealed resident don't smoke. During an observation of smoking on 12/30/2025 at 2:00pm revealed resident #1 and Resident #26 were outside with staff smoking. Both residents had smoking aprons on. During an interview with Resident #1 on 12/30/2025 at 2:05p.m., revealed that he goes out to smoke with staff three times a day. He said that all residents who smoke wear the smoking apron and that the staff watch them and are with them the whole time. During an interview with Resident #26 on 12/30/2025 at 2:13p.m., revealed that she smokes three times a day. She said staff are always made them wear a smoking apron. She said they disposed of the cigarettes in the ash tray and made sure not to throw the cigarette butts on the ground. During an interview with the ADM on 12/30/2025 at 3:55 p.m., he said he was not trained on the smoking assessment. He said the nurse on the hall was responsible for ensuring the smoking assessment was done. He said the smoking assessment was done when a resident expressed an interest in smoking. He said if a resident stopped smoking and started back up the nurse would need to do another smoking assessment. He said if the smoking assessment was not done the resident would not be able to smoke. He said the smoking assessment was monitored by the DON. He said the DON monitored the smoking assessment by reviewing it when it was done. He said he assumed Resident #1's smoking assessment was put as nonsmoker by mistake. During an interview with the MDSN on 12/30/2025 at 4:10 p.m., revealed she was trained on completing the smoking assessments. She said the smoking assessment was completed at admission if the resident was a smoker. She said the smoking assessment was also done when the resident requested one or if a resident had a change in condition. She said if the resident stopped smoking and started back up, she would have to do another smoking assessment on the resident. She said if the smoking assessment was not completed correctly the resident may not be safe due to a bad assessment. She said the ADON monitored to ensure the smoking assessments were done correctly and completely. She said she did not know how the ADON monitored the smoking assessments. She said she did not know why Resident #1 was marked as nonsmoker. During an interview with the DON on 12/30/2025 at 4:30 p.m., revealed he was trained on (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the smoking assessments. He said the smoking assessment had information that included the mental and physical capacity of which the resident could smoke. He said the smoking assessment was done upon request from the residents or family. He said the admitting nurse was responsible for filling out the smoking assessment. He said if the smoking assessment was not filled out correctly the staff would not know the status or resident's function ability. He said the IDT team monitored to ensure the smoking assessments were done correctly. He said the IDT team monitored by doing audits. He said the residents may not have been a smoker when admitted . Record review of Resident Assessment and Associated Processes Policy, dated 4/2025, revealed It is the policy of this facility that residents will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident, and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified.		