

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965612	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/16/2024
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NAME OF PROVIDER OR SUPPLIER MATHISON RETIREMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3637 WEST HIGHWAY 390 PANAMA CITY, FL 32405
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On January 16, 2024, an unannounced desk review revisit survey was completed for a complaint survey (2023011935), which originally ended on November 21, 2023, at Mathison Retirement Center, an assisted living facility in Panama City, FL. Based on electronic interview and supporting documentation, the deficiency was found to be corrected.	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE