



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

February 9, 2016

Administrator
Mathison Retirement Center
3637 West Highway 390
Panama City, FL 32405

RE: Licensure Survey With Complaint # 2015012595

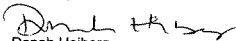
Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on February 4, 2016 by representatives of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than March 9, 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,


Donah Heiberg
Field Office Manager

DH/dh
Enclosure

XG90

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone: 850-412-4540; Fax: (850) 922-9162
AHCA.MyFlorida.com



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**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 02/09/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965612	(X3) DATE SURVEY COMPLETED 02/04/2016
NAME OF PROVIDER OR SUPPLIER MATHISON RETIREMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3637 WEST HIGHWAY 390 PANAMA CITY, FL 32405	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

CCR 2015012595

An unannounced Complaint survey CCR#2015012595 (in conjunction with the Biennial/Limited Nursing Services) was conducted on 2/3 - 2/4, 2016 at Mathison Retirement Assisted Living Facility. At the time of survey the allegations were not substantiated.