Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965612	A. BUILDING: _____ B. WING _____	R 08/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATHISON RETIREMENT CENTER	3637 WEST HIGHWAY 390 PANAMA CITY, FL 32405

(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
ZZ000	Initial Comments On August 26, 2026, an unannounced desk review revisit survey was completed for the biennial re-licensure survey originally ending on 06/30/2026 for Mathison Retirement Center in Panama City, FL. The deficiencies were found to be corrected.	ZZ000		
A 000	Initial Comments On August 26, 2026, an unannounced desk review revisit survey was completed for the biennial re-licensure survey originally ending on 06/30/2026 for Mathison Retirement Center in Panama City, FL. The deficiencies were found to be corrected.	A 000		