Department of Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205072	A. BUILDING: _____ B. WING _____	R 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARSHWOOD CENTER	**33 ROGER STREET LEWISTON, ME 04240**

(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
T 001	Initial Comments On 2/20/25 an on-site unannounced visit was conducted at Marshwood Center to follow up on a deficiency cited at the Recertification survey conducted on 12/19/24. It was determined that Marshwood Center was in substantial compliance with 10-144 CMR Chapter 110-Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.	T 001		

Department of Health and Human Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE