STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-161	A. BUILDING: _____ B. WING _____	R 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKWOOD	207 SUMMERPINE PLACE KANNAPOLIS, NC 28081

(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
{V 000}	INITIAL COMMENTS A follow up survey was completed on 6-26-23. No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600 Supervised Living for Adults with Developmental Disabilities. This facility is licensed for three and currently has a census of three. The survey sample consisted of audits of one current client.	{V 000}		