**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

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**NAME OF PROVIDER OR SUPPLIER**  
**BROOK STONE LIVING CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
8990 HIGHWAY 17 SOUTH  
POLLOCKSVILLE, NC  28573

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**SUMMARY STATEMENT OF DEFICIENCIES**  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**  
**TITLE**

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**Electronically Signed**  
09/11/2015

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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**FORM CMS-2567(02-99) Previous Versions Obsolete**  
Event ID: AOL811  
Facility ID: 923510  
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