PRINTED: 07/18/2025 FORM APPROVED

Division of Health Service Regulation

MML041-753 B. WING		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4004 CORNERROCK DR GREENSBORO, NC 27406 (A) ID PREFIX TAG (A) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH OBERCETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 INITIAL COMMENTS An annual survey was attempted on 6/30/25. According to the Owner there are no clients being served at the facility. The last time clients were served at the facility was 5/12/25. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. Interview on 6/30/25 with both the Owners revealed no clients had been served at the facility since Former Client #1 was discharged on 5/12/25. Review on 6/30/25 of Former Client #1's record revealed: -An admission date of 3/7/25; -An age of 10;			MHI 041-753	B. WING		06/30/2025	
LOCKWOOD PLACE 4004 CORNERROCK DR GREENSBORO, NC 27406 CAJ ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 000			WII1E041-733			00/30/2023	
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
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Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE