

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-753	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/30/2025
NAME OF PROVIDER OR SUPPLIER LOCKWOOD PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 4004 CORNERROCK DR GREENSBORO, NC 27406		
(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	<p>INITIAL COMMENTS</p> <p>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.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.</p> <p>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.</p> <p>Review on 6/30/25 of Former Client #1's record revealed: -An admission date of 3/7/25; -An age of 10; -A discharge date of 5/12/25.</p>	V 000		

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

TITLE

(X6) DATE