

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-753</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/27/2026</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LOCKWOOD PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4004 CORNERROCK DR GREENSBORO, NC 27406</b>
---	---

(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><b>INITIAL COMMENTS</b></p> <p>An annual survey was attempted on 5/27/26. According to the Owner/Assistant Director, 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 5/27/26 with the Owner/Assistant Director revealed:</p> <ul style="list-style-type: none"> <li>-No clients had been served at the facility since the last attempted survey on 2/5/26;</li> <li>-They had considered changing their license to serve as a respite facility;</li> <li>-"We want to use it as an emergency home."</li> </ul>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------