

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN**

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License #: **5649-14-009**

Organization Name: **Trinity Residential Services, LLC**

Date of Inspection: **02-13-2026**

Program Type/Facility Name: **14-009**

No Violation

General Comments / Recommendations:

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

(Signature of Organization Representative)

Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined