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



Investigation ID: **718**
License #: **909-14-003**
Organization Name: **Harbor Point Behavioral Health Center**

Date of Inspection: **04-23-2026**
Program Type/Facility Name: **14-003 Harbor Point Behavioral Health**

# 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.

| Evmarian Cabey, Licensing Specialist | (Signature of Organization Representative) | Date |
|---|---|---|

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