Electronically Delivered

March 24, 2026

Licensee
True Alliance Inc
13946 West Preserve Boulevard
Burnsville, MN 55337

RE: Project Number(s) SL39102016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 3, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39102	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUE ALLIANCE INC	13946 WEST PRESERVE BOULEVARD BURNSVILLE, MN 55337

(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
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39102016-0 On March 2, 2026 , through March 3, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during medication administration by one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 3, 2026, at 7:59 a.m., the surveyor observed ULP-E perform hand hygiene, apply gloves, bring a laptop to the kitchen, and remove R1's medication from the medication cabinet.	0 510		

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0 510	Continued From page 2 ULP-E checked R1's blood pressure. ULP-E logged onto the laptop and documented R1's blood pressure results. ULP-E gathered R1's diabetic supplies, checked R1's blood sugar and documented the results in the electronic health record (EHR) on the laptop. ULP-E then removed R1's medications from a medication box into a medication cup. ULP-E reviewed R1's medication orders in the EHR and then poured R1's medication cup into her gloved hands. ULP-E counted the medications and then put the medications back into the medication cup and administered them to R1. ULP-E documented the administration in the laptop and put the medication bin back in the medication cabinet. ULP-E removed her gloves and performed hand hygiene. ULP-E did not remove gloves between the tasks noted above. On March 3, 2026, at 11:32 a.m., clinical nurse supervisor (CNS)-C stated she expected the ULP to perform hand hygiene prior to applying gloves and again after gloves were removed. CNS-C further stated the ULP should have changed gloves between performing different tasks, especially tasks involving bodily fluids such as blood sugar checks. The licensee's Infection Control policy dated July 11, 2022, indicated gloves are worn when touching blood, body fluids, secretions, excretions, non-intact skin, mucous membranes, or contaminated items. Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between resident contacts, and when indicated to prevent transfer of microorganisms between resident or the environment. No other information was provided.	0 510		

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0 510	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) by failing to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 660		

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0 660	Continued From page 4 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on January 8, 2026, to provide direct care and services to the facility's residents. ULP-D's employee record contained a negative one step TST dated January 5, 2026; however, ULP-D's employee record lacked evidence of a second step TST. On March 3, 2026, at 12:08 p.m., owner (O)-A reviewed ULP-D's record and stated it did not include a second step TST but would contact ULP-D to see if he had a copy of the second step TST. On March 3, 2026, at 8:33 p.m., the surveyor received an email from O-A with ULP-D's TST results. The document only included the first step TST dated January 5, 2026, it did not include a second step TST. The licensee's Tuberculosis Screening/Prevention policy dated July 11, 2022, indicated employees receive baseline TB screening upon hire to test for M. tuberculosis. The baseline test may be either TST (2-step) or BAMT No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content. This had the potential to affect all residents, staff, and visitors of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 6 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Manual dated August 1, 2025, was reviewed and lacked the following: - arrangement with other faculties - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing use of volunteers, including the process/role for integration On March 3, 2026, at 12:12 p.m., owner (O)-A stated the licensee had arrangements with another assisted living facility nearby and would look for the documentation confirming the arrangement. O-A stated he would also look for the missing policies noted above and email them to the surveyor if found. The surveyor did not receive any additional documents related to the missing content above. The licensee's Emergency Preparedness policy dated July 11, 2022, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.	0 680		

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0 680	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775		

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0 775	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 3, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	01370		

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01370	Continued From page 10 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-D and ULP-E) to include all required content.	01370		

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01370	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on January 8, 2026, to provide direct care and services to the licensee's residents. ULP-D's employee record lacked evidence of training for the following topics: -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family ULP-D's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting ULP-E ULP-E was hired on May 16, 2023, to provide direct care and services to the licensee's residents.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39102	A. BUILDING: _____ B. WING _____	03/03/2026

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01370	Continued From page 12 On March 3, 2026, at 7:59 a.m., the surveyor observed ULP-E administer medications to R1. ULP-E's employee record lacked evidence of training for the following topics: -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family -understanding appropriate boundaries between staff and residents and the resident's family ULP-E's employee record lacked evidence of competency evaluation for the following topics: -appropriate and safe techniques in personal hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assistance with toileting -standby assistance techniques and how to perform them On March 3, 2026, at 11:59 a.m., owner (O)-A reviewed ULP-D and ULP-E's training documents and training transcript. O-A stated ULP-D and ULP-E's records lacked documentation of the above training and competency evaluations. O-A stated he was unsure of why ULP-D and ULP-E did not complete the above training and stated it must have been accidentally missed. Clinical nurse supervisor (CNS)-C stated all ULP were competency tested on all required topics by the registered nurse (RN); however, they did not document all areas individually for any of the ULP. CNS-C stated she would implement the new documents for all ULP that listed individual competencies.	01370		

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01370	Continued From page 13 The licensee's Staff Competency policy dated July 11, 2022, indicated training and competency evaluation for all ULPs would include: e. appropriate and safe techniques in person hygiene and grooming including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing and assisting with toileting g. standby assistance techniques and how to perform them j. communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family l. understanding appropriate boundaries between staff and residents and the resident's family No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive,	01380		

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01380	Continued From page 14 and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-D and ULP-E) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on January 8, 2026, to provide direct care and services to the licensee's residents. ULP-D's employee record lacked evidence of training for the following topics: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the resident	01380		

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01380	Continued From page 15 ULP-D's employee record lacked evidence of competency evaluation for the following topics: -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments ULP-E ULP-E was hired on May 16, 2023, to provide direct care and services to the licensee's residents. On March 3, 2026, at 7:59 a.m., the surveyor observed ULP-E administer medications to R1. ULP-E's employee record lacked evidence of training for the following topics: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the resident -range of motion and positioning ULP-E's employee record lacked evidence of competency evaluation for the following topics: -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments On March 3, 2026, at 11:59 a.m., owner (O)-A reviewed ULP-D and ULP-E's training documents and training transcript. O-A stated ULP-D and ULP-E's record lacked documentation of the above training and competency evaluations. O-A stated he was unsure of why ULP-D and ULP-E did not complete the above training and stated it must have been accidentally missed. Clinical nurse supervisor (CNS)-C stated all ULP were competency tested on all required topics by the	01380		

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01380	Continued From page 16 registered nurse (RN); however, they did not documented all areas individually for any of the ULP. CNS-C stated she would implement the new documents for all ULP that listed individual competencies. The licensee's Staff Competency policy dated July 11, 2022, indicated training and competency evaluation for all ULPs would include: ii. Basic knowledge of body functioning and changes in body function, injuries or other reportable changes iii. recognizing physical, emotional, cognitive and development needs of the resident vii. safe transfer techniques and ambulation viii. range of motion and positioning ix. administering medications or treatments as required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and	01620		

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01620	Continued From page 17 the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01620		

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01620	Continued From page 18 licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on October 14, 2022, with diagnoses that included schizophrenia (brain disorder that affects how a person thinks, feels, and acts, making it difficult to distinguish between real and unreal experiences). R1's service plan dated February 16, 2026, indicated R1 received services to include grooming, dressing, bathing reminders, incontinence care, safety checks, behavior management, compression stockings, daily blood pressure checks, PRN (as needed) wound care, medication setup and medication administration. R1's ongoing nursing assessments dated September 1, 2025, December 1, 2025, and March 1, 2026, were reviewed. The December 1, 2025, assessment was completed 91 days after the date of the previous assessment, thus exceeding 90 calendar days. On March 3, 2026, at 11:07 a.m., clinical nurse supervisor (CNS)-C reviewed R1's	01620		

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01620	Continued From page 19 comprehensive assessments and stated the December 1, 2025, assessment was completed late. The licensee's Assessment and Reassessment policy dated August 18, 2022, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of	01640		

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01640	Continued From page 20 the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on October 14, 2022, with diagnoses that included schizophrenia (brain disorder that affects how a person thinks, feels, and acts, making it difficult to distinguish between real and unreal experiences). R1's service plan dated February 16, 2026, indicated R1 received services to include grooming, dressing, bathing reminders, incontinence care, safety checks, behavior management, compression stockings, daily blood pressure checks, PRN (as needed) wound care, medication setup and medication administration. On March 3, 2026, at 7:59 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's medications, check his blood pressure and blood sugar. R1 had a dressing on his right lower extremity.	01640		

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01640	Continued From page 21 R1's medication administration record dated March 2026, indicated the ULP checked R1's blood sugar once a day. R1's signed prescriber orders dated December 4, 2025, indicated to check R1's blood sugar once a day in the morning. R1's progress notes dated February 25, 2026, indicated the following: "The resident's left lower extremity skin is intact and dry, with no open areas noted at this time. The right lower extremity presents with a small open wound located on the medial aspect of the lower leg, just proximal to the medial malleolus (inner ankle). A new wound dressing was applied per protocol". R1's record lacked signed prescriber orders for wound care. On March 3, 2026, at 11:18 a.m., clinical nurse supervisor (CNS)-C stated the nurse completed wound care to R1's right lower extremity every week and as needed. CNS-C reviewed R1's service plan and stated it did not include daily blood sugar check or weekly wound care. CNS-C stated the services for blood sugar checks and wound care were not entered into the electronic health record system correctly which is why they were not listed on the service plan. CNS-C stated she corrected this and will have R1 sign the updated service plan. The licensee's Service Plan policy dated July 11, 2022, indicated an individualized service plan is implemented for all residents. The initial service plan and any revisions are signed by the representative from the licensee and the resident or resident's representative, indicating agreement	01640		

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01640	Continued From page 22 with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used	01790		

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01790	Continued From page 23 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed training and competency for two unlicensed personnel (ULP-D and ULP-E) providing medications to residents for unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a	01790		

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01790	Continued From page 24 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on January 8, 2026, to provide direct care and services to the licensee's residents. ULP-D's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. ULP-E ULP-E was hired on May 16, 2023, to provide direct care and services to the licensee's residents. On March 3, 2026, at 7:59 a.m., the surveyor observed ULP-E administer medications to R1. ULP-E's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On March 3, 2026, at 11:40 a.m., owner (O)-B and clinical nurse supervisor (CNS)-C reviewed ULP-D and ULP-E's training documents and transcripts and stated their records lacked documentation of training and competencies for unplanned time away. CNS-C stated all ULP were trained and competency tested for unplanned time away; however, the licensee's current	01790		

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01790	Continued From page 25 training documents did not include this for any ULP. CNS-C stated she has different training documents that would include training and competencies for unplanned time away and would implement these new forms. The licensee's Staff Competency policy dated July 11, 2022, indicated all residents will receive quality service delivered by staff who are educated and competent in the delivery of assisted living services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39102	A. BUILDING: _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUE ALLIANCE INC	13946 WEST PRESERVE BOULEVARD BURNSVILLE, MN 55337

(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
01820	Continued From page 26 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on October 14, 2022, with diagnoses that included schizophrenia (brain disorder that affects how a person thinks, feels, and acts, making it difficult to distinguish between real and unreal experiences). R1's service plan dated February 16, 2026, indicated R1 received services to include medication administration. On March 3, 2026, at 7:59 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's medications, R1's signed prescriber orders dated December 4, 2025, included the following as needed (PRN) medications: -magnesium citrate 200 milligrams (mg); take one tablet by mouth daily as needed (constipation) -Nicotine lozenge 2 mg; dissolve one lozenge in mouth for 20 minutes every one hour as needed (smoking) -Nicotine lozenge 4 mg; dissolve one lozenge in mouth for 20 minutes every one hour as needed (smoking) -Nicotine Transdermal Patch 7 mg/24 hours; Apply one patch to arms or back once daily as needed (smoking) -Phosphate enema; insert one enema rectally one time as needed (constipation) R1's medication administration record dated March 2026, did not include the following medications:	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 27 -magnesium citrate 200 milligrams (mg); take one tablet by mouth daily as needed (constipation) -Nicotine lozenge 2 mg; dissolve one lozenge in mouth for 20 minutes every one hour as needed (smoking) -Nicotine lozenge 4 mg; dissolve one lozenge in mouth for 20 minutes every one hour as needed (smoking) -Nicotine Transdermal Patch 7 mg/24 hours; Apply one patch to arms or back once daily as needed (smoking) -Phosphate enema; insert one enema rectally one time as needed (constipation) On March 3, 2026, at 11:17 a.m., clinical nurse supervisor (CNS)-C reviewed R1's MAR and stated the magnesium citrate, Nicotine lozenges, Nicotine patch and phosphate enema were all discontinued by R1's provider. However, CNS-C could not locate signed prescriber orders to discontinue these medications. CNS-C stated she requested signed orders for these discontinued medications from R1's provider after they could not be located for the surveyor. The licensee's Prescriber's Orders policy dated July 11, 2022, indicated written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 28 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1).	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39102	A. BUILDING: _____ B. WING _____	03/03/2026

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01940	Continued From page 29 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on October 14, 2022, with diagnoses that included schizophrenia (brain disorder that affects how a person thinks, feels, and acts, making it difficult to distinguish between real and unreal experiences). R1's service plan dated February 16, 2026, indicated R1 received services to include grooming, dressing, bathing reminders, incontinence care, safety checks, behavior management, compression stockings, daily blood pressure checks, PRN (as needed) wound care, medication setup and medication administration. R1's service plan did not include daily blood sugar checks or weekly wound care. On March 3, 2026, at 7:59 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's medications, check his blood pressure and blood sugar. R1 had a dressing on his right lower extremity. R1's medication administration record dated March 2026, indicated the ULP checked R1's blood sugar once a day. R1's serviced delivered document dated February 1, 2026, through March 2, 2026, indicated the	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 30 ULP assisted R1 with the following treatments: -compression stockings -daily blood pressure checks R1's progress notes dated February 25, 2026, indicated the following: "The resident's left lower extremity skin is intact and dry, with no open areas noted at this time. The right lower extremity presents with a small open wound located on the medial aspect of the lower leg, just proximal to the medial malleolus (inner ankle). A new wound dressing was applied per protocol". R1's record lacked signed prescriber orders for wound care. On March 3, 2026, at 11:18 a.m., clinical nurse supervisor (CNS)-C stated the nurse completed wound care to R1's right lower extremity every week and as needed The licensee provided the surveyor with an Individualized Treatment and Therapy Plan for R1 dated March 2, 2026, which was completed after the start of survey. The treatment plan indicated R1 received wound care, daily blood pressure checks, monthly vital signs and weekly weights. The treatment plan did not include daily blood sugar checks or compression stockings. R1's record lacked evidence of an Individualized Treatment or Therapy Management Plan to include the following required content: - statement of the type of service that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 31 - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On March 3, 2026, at 11:27 a.m., CNS-C reviewed R1's individualized treatment management plan dated March 2, 2026, and stated it was created after the start of survey, and it did not include all treatments R1 received. CNS-C stated R1's record lacked and individualized treatment management plan that included the required content as listed above. The licensee's Treatment and Therapy Management policy dated July 11, 2022, indicated the registered nurse (RN) or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. type of service to be provided b. procedures for documenting treatments or therapies c. procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. identification of treatment or therapy tasks delegated to unlicensed personnel e. procedures for notifying the RN or licensed health professional when problems arise related to the treatment or therapy service No further information was provided.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 32 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on October 14, 2022, with diagnoses that included schizophrenia (brain disorder that affects how a person thinks, feels,	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 33 and acts, making it difficult to distinguish between real and unreal experiences). R1's service plan dated February 16, 2026, indicated R1 received services to include grooming, dressing, bathing reminders, incontinence care, safety checks, behavior management, compression stockings, daily blood pressure checks, PRN (as needed) wound care, medication setup and medication administration. R1's service plan did not include daily blood sugar checks or weekly wound care. On March 3, 2026, at 7:59 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's medications, check his blood pressure and blood sugar. R1 had a dressing on his right lower extremity. R1's progress notes dated February 25, 2026, indicated the following: "The resident's left lower extremity skin is intact and dry, with no open areas noted at this time. The right lower extremity presents with a small open wound located on the medial aspect of the lower leg, just proximal to the medial malleolus (inner ankle). A new wound dressing was applied per protocol". On March 3, 2026, at 11:18 a.m., clinical nurse supervisor (CNS)-C stated the nurse completed wound care to R1's right lower extremity every week and as needed R1's record lacked signed prescriber orders for wound care. On March 3, 2026, at 11:28 a.m., CNS-C reviewed R1's record and stated it lacked signed prescriber orders for R1's weekly wound care to his right lower extremity.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 34 The licensee's Treatment and Therapy Management policy dated July 11, 2022, indicated the registered nurse (RN) or licensed health professional will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: a. resident name b. description of the treatment or therapy to be provided c. frequency d. other pertinent information No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

True Alliance Inc
13946 West Preserve Boulevard
Burnsville, MN 55337
Dakota County
Parcel:

Phone:

License Info

License: HFID 39102

Risk:
License:
Expires on:
CFPM: Ifrah Sheikh Shafie
CFPM #: 63894; Exp: 10/05/2026

Inspection Info

Report Number: F1018261050
Inspection Type: Full - Single
Date: 3/3/2026 Time: 2:51:27 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Establishment is a residential house with residential equipment.

Establishment does all same day service of foods.

Dishwasher tested at 160F.

Separate hand sinks for food prep and hand washing.

Floors, walls, ceiling, equipment and physical facilities were in good condition during this inspection.

Discussed illness policy and viewed illness log, discussed pest control and vomit clean up plan.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1018261050 from 3/3/2026

Ifrah Shafie

Rebecca Prestwood

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

True Alliance Inc
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018261050
Inspection Type: Full
Date: 3/3/2026
Time: 2:51:27 PM

Food Temperature: Product/Item/Unit: fruit**; Temperature Process:** Cold-Holding
Location: refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: cheese**; Temperature Process:** Cold-Holding
Location: refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

True Alliance Inc
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018261050
Inspection Type: Full
Date: 3/3/2026
Time: 2:51:27 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39102016	**Date:** 3/3/2026
Facility Name: True Alliance Inc.	
Facility Address: 13946 W Preserve Blvd., Burnsville, MN 55337	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9]

   Comments:

   An unapproved lock was installed on the front door of the facility which prevented ready operability of the door and obstructed egress from the facility. The lock was mounted above the allowable height on the door, and the lock required a key to open the door from the egress side of the door. This lock posed a hazard to occupants of the facility as it may prevent or obstruct egress through a marked exit door. The lock was removed by the owner (O)-B during the survey.

   An unapproved lock was installed on the rear patio gate which prevented ready operability of the gate and obstructed egress from the facility. A padlock requiring number combination to open was installed on the bolt lock which secured the gate on the rear patio requiring special knowledge to unlock. The rear porch was in a marked path of egress with an exit sign on the door leading to the patio, but the locked gate prevented ready access to the public right of way. The lock on the rear gate was removed by O-B during the survey.

3. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: Dozens of cigarette butts were located on the ground in the rear yard of the facility. These cigarette butts were not properly disposed of. All smoking materials should be properly disposed of in approved receptacles to prevent risk of fire.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide staff actions for evacuation in the FSEP for the facility. General fire safety information was provided, however no site-specific information or any plan for evacuation was provided. The FSEP should include specific employee procedures to take during a fire or similar emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide resident actions for evacuation in the FSEP for the facility. General fire safety information was provided, however no site-specific information or any plan for evacuation was provided. The FSEP should include specific resident procedures to take during a fire or similar emergency.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee provided general training through a third-party software for staff, but trainings were not site specific and did not include training on evacuation actions or specific training on the FSEP for staff. Staff should receive training upon hire and twice a year thereafter.