DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electrically delivered via Email

July 18, 2025

Administrator
Saint Cloud Hospital
1406 6th Ave North
Saint Cloud, MN 56303

RE: Event ID: J11H11

Dear Administrator:

An abbreviated standard survey was completed at your agency on July 14, 2025 by the Minnesota State Department of Health, for the purpose of investigating a complaint and assessing compliance with federal regulations and state licensing statutes.

We are pleased to inform you that this investigation resulted in no deficiencies being issued.

Enclosed is your copy fo the Federal Form CMS-2567 and State Form. A plan of correction is not required.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	240036	A. BUILDING _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD HOSPITAL	1406 6TH AVE NORTH SAINT CLOUD, MN 56303

(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) COMPLETION DATE
A 000	INITIAL COMMENTS On 7/10/25-7/14/25, a substantial allegation investigation and abbreviated survey was conducted to investigate an alleged violation of the Conditions of Participation for hospitals participating in Medicare, specifically the Condition of Participation of Patient Rights at 42 CFR 482.13. St. Cloud Hospital was found in compliance with the Federal regulations for Hospital Conditions of Participation's at 42 CFR, part 482. The following complaint was investigated: H00369087C (MN00114466, MN00114454, MN00114450).	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH

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July 18, 2025

Ms. Joy Plamann, Administrator
Saint Cloud Hospital
1406 6th Ave North
Saint Cloud, MN 56303

RE: Project Number H00369087C

Dear Ms. Plamann:

On July 14, 2025, an abbreviated survey was completed at the above facility by the Minnesota Departments of Health and Public Safety for the purpose of assessing compliance with State standards for licensure based on Minnesota Statutes §144.55, Subd. 3.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

Enclosed is your copy of the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Thank you for your cooperation.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

cc: Licensing and Certification File O980

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00639	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD HOSPITAL	1406 6TH AVE NORTH SAINT CLOUD, MN 56303

(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
6 000	INITIAL COMMENTS In accordance with MN State Statute 144.55 Subd 3., for the purpose of hospital licensure, the commissioner of health shall use as minimum standards the hospital certification regulations. An abbreviated survey was conducted from 7/10/25-7/14/25, to investigate an alleged violation of State requirements for Hospital Licensure pertaining to: §482.13 Condition of Participation: Patient's Rights. Please refer to CMS 2567 for additional information.	6 000		