OKLAHOMA
State Department
of Health

Delivery via email to: soonerstationed@islllc.com

June 3, 2025

License Number: AL1415

Mr. Michael Dean, Administrator
Sooner Station At University North Park
2803 24th Avenue NW
Norman, OK 73069

RE: Survey Event ID: 1Y7611

Dear Mr. Dean:

On **May 7, 2025**, agents from our office concluded a State Licensure survey with complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **May 7, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used

by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
IDRCoordinator@health.ok.gov
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;

- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Sooner Station
Address: 2803 24th Ave NW
City, State, Zip: Norman, OK 73069
Provider #: AL1415
Complaint #: OK00065410
Investigation Date(s): 05/06/25-05/07/25

ALLEGATION(S)
The center failed to ensure a safe, clean, comfortable and homelike environment
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 05/06/2025 at 6:45 a.m.

A sample of 11 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation: Observations were made of the center which showed industrial-type fans positioned towards walls and ceilings in hallways, common areas, and one resident apartment. One resident apartment was blocked off due to excessive leaking of rain water into the apartment and the resident was relocated to another apartment within the assisted living center. Review of records included resident contracts, resident health charts, and contracts with repair companies. Interviews with staff, residents, families, and contractors were conducted. The center showed to have leaking inside of the building due to rain and has contractors working to repair the building, which was constructed incorrectly and allowing rain water to enter the building at various points. There is no airbourne mold in the center and the center is proactive with repairs as evidenced by invoices, contracts, and interviews with contractors. The residents and family interviewed had no grievances with the leaking or construction.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 05/07/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Sooner Station
Address: 2803 24th Ave NW
City, State, Zip: Norman, OK 73069
Provider #: AL1415
Complaint #: OK00067395
Investigation Date(s): 05/06/25-05/07/25

ALLEGATION(S)
The center failed to ensure a safe, clean, comfortable and homelike environment
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 05/06/2025 at 6:45 a.m.

A sample of 11 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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Oklahoma State Department of Health
Long Term Care Service

Date report completed: 05/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1415	A. BUILDING: _____ B. WING _____	C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOONER STATION AT UNIVERSITY NORTH PA	2803 24TH AVENUE NW NORMAN, OK 73069

(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
C 000	INITIAL COMMENTS A relicensure and complaint survey (#OK00065410 and #OK00067395) was conducted from 05/06/25 through 05/07/25. Deficiencies were cited as a result of the survey. Facility Census: 89	C 000		
C 510 SS=D	310:663-5-1 ASSESSMENT TIMEFRAMES Each assisted living center shall use the admission and comprehensive assessment designated by the Department. This Rule is not met as evidenced by: Based on record review and interview, the center failed to use the admission assessment designated by the department for 2 (#4 and #7) of 11 residents sampled for admission assessments. The administrator identified 89 residents resided in the center. Findings: A policy titled "Resident Assessment and Service	C 510		

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C 510	Continued From page 1 Plan," dated 07/01/21, read in part, "Each assisted living center shall use the admission and comprehensive assessment designated by the Department." 1. An undated "Physician Order sheet," showed Resident #4 was admitted to the center on 11/21/24 with diagnoses to include supraventricular tachycardia, essential primary hypertension, and osteoporosis. A review of Resident #4's medical chart showed no admission assessment utilizing the designated admission assessment form. 2. An undated "Physician Order sheet," showed Resident #7 was admitted to the center on 12/15/23 with diagnoses to include age-related cognitive decline, hypertension, neuropathy, and chronic pain. A review of Resident #7's medical chart showed no admission assessment utilitizing the designated admission assessment form. On 05/07/25 at 9:19 a.m., the DON was asked for the admission assessment for Resident #4. The DON stated, "[Resident #4] doesn't have one because I didn't realize there was a separate form for assessments." On 05/07/25 at 9:21 a.m., the DON was asked for the admission assessment for Resident #7. The DON stated, "If it's not in the chart they don't have one." The DON was asked if Resident #7 had the assessment and they stated, "No."	C 510		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES	C 522		

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C 522	Continued From page 2 (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for 1 (#6) of 11 residents sampled for comprehensive assessments. The administrator identified 89 residents resided in the center. Findings: A "Pre-admission Assessment," dated 06/07/23, showed Resident #6 was admitted to the center on 06/14/23 with diagnoses to include heart faliure, scoliosis, and chronic kidney disease. A review of Resident #6's medical chart did not show a comprehensive assessment was completed for 2024. On 05/07/25 at 9:31 a.m., the DON was asked what the center's policy was on comprehensive assessments. They stated, "On move in, annual, and change of condition." The DON was asked for the annual comprehensive assessment for	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 522	Continued From page 3 Resident #6. They stated, "[Resident #6] does not have one."	C 522		
C 711 SS=F	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure violations cited by the fire marshal were corrected for 2024. The administrator identified 89 residents resided in the center. Findings: A document titled "Fire Marshal Reinspection," dated 08/01/24, read in part, "Fail. Assisted Living Trash Room First Floor. Abatement of electical hazards. Fail. Riser Room. Inspection, testing, and maintenance. The inspector will return on or after 08/14/24."	C 711		

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C 711	Continued From page 4 On 05/06/25 at 12:01 p.m., the administrator was asked if the fire marshal inspection dated 08/01/24 showed the center cleared or failed the fire marshal inspection. The administrator stated, "We failed two parts." They were asked when was the last time fire mashal was out and if the center passed the reinspection. The administrator stated, "I think they were out a few days ago. Let me check if he left a report." On 05/06/25 at 12:43 p.m. the administrator stated, "[Maintenance director] emailed pictures of corrections to fire marshall, but never heard back. They just reached out to the fire marshal to get a response." On 05/07/25 at 1:05 p.m., the administrator was asked if the center had obtained a cleared fire marshall report. They stated, "We still have not heard back."	C 711		

OKLAHOMA
State Department of Health

Delivery via email to: soonerstationed@islllc.com

June 17, 2025

License Number: AL1415

Mr. Michael Dean, Administrator
Sooner Station At University North Park
2803 24th Avenue Nw
Norman, OK 73069

RE: Survey Event 1Y7611

Dear Mr. Dean:

On **May 7, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 17, 2025**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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C 522	Continued From page 2 (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for 1 (#6) of 11 residents sampled for comprehensive assessments. The administrator identified 89 residents resided in the center. Findings: A "Pre-admission Assessment," dated 06/07/23, showed Resident #6 was admitted to the center on 06/14/23 with diagnoses to include heart faliure, scoliosis, and chronic kidney disease. A review of Resident #6's medical chart did not show a comprehensive assessment was completed for 2024. On 05/07/25 at 9:31 a.m., the DON was asked what the center's policy was on comprehensive assessments. They stated, "On move in, annual, and change of condition." The DON was asked for the annual comprehensive assessment for	C 522	POC being Submitted on optional template	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/13/2025** **Facility Name:** Sooner Station at University North Park **License Number:** AL1415 **Survey Event ID:** 1Y7611 **Date Survey Completed: 5/7/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C510	Based on: record review and interview, the center failed to use the admission assessment designated by the department for 2 (#4 and #7) of 11 residents sampled for admission assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Immediate assessments were completed for residents #4 and #7 who had missing or incomplete admission assessments. The assessments were conducted by the DHW to ensure accuracy and completeness.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit was conducted of all residents to identify any other residents who may have had incomplete admission assessments. Affected records were updated immediately.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Implemented a standardized assessment tool/log and checklist to guide completion. Utilize assessment tracking log to monitor completion and due dates.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	DHW/ED or designee will conduct audits of admission assessments upon admission. DHW/ED or designee will audit charts upon move in and at random to ensure that all residents assessments are accurate. Complaince will be tracked using the EMAR assessment log. DHW or designee and ED will discuss report and signoff to ensure compliance. Audits will be filed in binder located in DHW's office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/17/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date 6/13/2025**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/13/2024** **Facility Name:** Sooner Station at University North Park **License Number:** AL1415 **Survey Event ID:** 1Y7611 **Date Survey Completed: 5/7/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522	Based on: record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for 1 (#6) of 11 residents sampled for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Immediate comprehensive assessments were completed for resident #6.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit was conducted of all residents to identify any other residents who may have had incomplete comprehensive assessments. Affected records were updated immediately, and any comprehensive needs were addressed.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Implemented a standardized assessment tool/log and checklist to guide completion. Utilize assessment tracking log to monitor completion and due dates.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	DHW/ED or designee will conduct weekly audits of assessments. DHW/ED or designee will audit charts upon move in and at random to ensure that all residents assessments are accurate. Compliance will be tracked using the EMAR assessment log. DHW/ED or designess will discuss audits and sign off to ensure compliance. Audits will be filed in binder located in DHW's office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/17/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 6/13/2025**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/11/2025** **Facility Name:** Sooner Station at University North Park **License Number:** AL1415 **Survey Event ID:** 1y7611 **Date Survey Completed: 5/7/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 711	Based on: Based on record review and interview, the facility failed to ensure violations cited by the fire marshal were corrected for 2024.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Failed issues on fire inspection were cleared on 12/30/2024 and we now have report onsite (see attached).

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Corrections were made, photographed, documented and emailed to fire dept. inspector on 8/16/2024 per his request.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	n/a
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Contiuned follow-up attemps are made with fire marshall will be made until saticfatory fire inspection results are obatained.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Fire inspection results will be addressed until saticfatory fire inspection results are received Monthly auditing of monitoring will be signed off on for QA Fire inspections are documented in TELS system (equipment monitoring system)
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date 6/13/2025**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Norman Fire Department
Office of the Fire Marshal

415 East Main, Norman, OK 73071
(405) 307-7200

Occupant Name:	Sooner Station Senior Living	**Inspection Date:**	8/1/2024 (Initial Insp. Date: 6/14/2024)
Suite:		**InspectionType:**	Reinspection #1 (Complaint, Annual Inspection)
Address:	2803 24Th Avenue Northwest	**Inspected By:**	Toby Kerby 405-953-5101 toby.kerby@normanok.gov
City:	NORMAN		
Contacts:	*-None-*	**Property Owner:**	*-None-*

Insp. Result	Location	Code Set	Code
Fail - Cleared		Norman, OK Amended IFC 2018 CHAPTER 9 FIRE PROTECTION AND LIFE SAFETY SYSTEMS	901.6 - Inspection, testing and maintenance. (see photo 1.1)
	✓ ***Cleared on 8/1/2024***		
Fail - Cleared		Norman, OK Amended IFC 2018 CHAPTER 9 FIRE PROTECTION AND LIFE SAFETY SYSTEMS	904.12 - Commercial cooking systems. (see photo 2.1)
	✓ ***Cleared on 8/1/2024***		
Fail - Cleared		Norman, OK Amended IFC 2018 CHAPTER 4 EMERGENCY PLANNING AND PREPAREDNESS	405.5 - Record keeping. (see photo 3.1)
	✓ ***Cleared on 8/1/2024***		
	Inspector Comments: Fire drills were provided in person and emailed as requested. List of requirements for each occupancy type for fire drills were reviewed. More fire drills with all residents were recommended.		
Fail	Assisted living - trash room- 1st floor	Norman, OK Amended IFC 2018 CHAPTER 6 BUILDING SERVICES AND SYSTEMS	604.1 - Abatement of electrical hazards.
Fail - Cleared	Assisted living- 2nd floor	Norman, OK Amended IFC 2018 CHAPTER 9 FIRE PROTECTION AND LIFE SAFETY SYSTEMS	906.2 - General requirements. (see photo 4.1)
	✓ ***Cleared on 8/1/2024***		
Fail	Riser room	Norman, OK Amended IFC 2018 CHAPTER 9 FIRE PROTECTION AND LIFE SAFETY SYSTEMS	901.6 - Inspection, testing and maintenance.

Inspector Comments: Please let me know when the remaining issues are corrected. Pictures of corrections texted or emailed will suffice for the remaining issues.

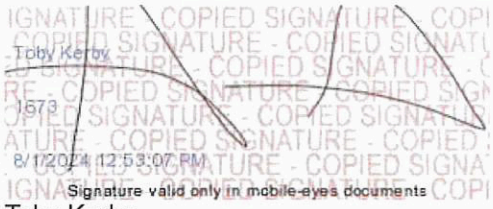
The inspector will return on or after 8/14/2024.

Thank you for your cooperation in keeping your business and our community safe! If you have any questions, please contact the fire inspector listed at the top of this report.

Company Representative:

1673
8/1/2024 12:53:07 PM
Signature valid only in mobile-eyes documents

Inspector:

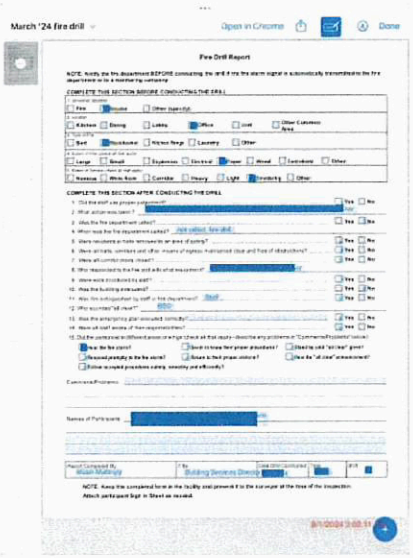


Toby Kerby
8/1/2024

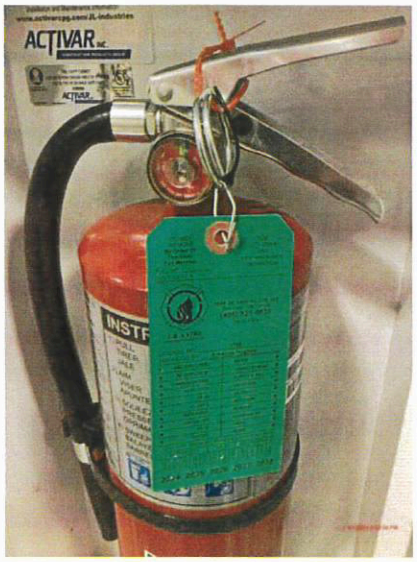
1.1 - 901.6.

2.1 - 904.12.

3.1 - 405.5.



4.1 - 906.2.



Ref: 1547-1673

Norman Fire Department
Office of the Fire Marshal

415 East Main, Norman, OK 73071
(405) 307-7200

Occupant Name:	Sooner Station Senior Living	**Inspection Date:**	12/30/2024 (Initial Insp. Date: 6/14/2024)
Suite:		**InspectionType:**	Reinspection #2 (Complaint, Annual Inspection)
Address:	2803 24Th Avenue Northwest	**Inspected By:**	Toby Kerby 405-953-5101 toby.kerby@normanok.gov
City:	NORMAN		
Contacts:	*-None-*	**Property Owner:**	*-None-*

Insp. Result	Location	Code Set	Code
Fail - Cleared	Assisted living - trash room- 1st floor	Norman, OK Amended IFC 2018 CHAPTER 6 BUILDING SERVICES AND SYSTEMS	604.1 - Abatement of electrical hazards.
	✓ ***Cleared on 12/30/2024***		
Fail - Cleared	Riser room	Norman, OK Amended IFC 2018 CHAPTER 9 FIRE PROTECTION AND LIFE SAFETY SYSTEMS	901.6 - Inspection, testing and maintenance.
	✓ ***Cleared on 12/30/2024***		

Inspector Comments: pictures in 2 emails from Sooner Station BSD <soonerstationbsd@islllc.com on 9/18/2024

Thank you for your cooperation in keeping your business and our community safe! If you have any questions, please contact the fire inspector listed at the top of this report.

Ref: 1547-1943

OKLAHOMA
State Department of Health

Delivery via email to: soonerstationed@islllc.com

June 25, 2025

License Number: AL1415
Survey Event ID: 1Y7612

Mr. Michael Dean, Administrator
Sooner Station At University North Park
2803 24th Avenue Nw
Norman, OK 73069

Dear Mr. Dean:

On **June 23, 2025**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **May 7, 2025,** have now been corrected and your facility is in compliance with licensure standards effective **June 17, 2025**.

If you have any questions concerning the information in this letter, please contact this office at (405) 426-8200.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1415	A. BUILDING: _____ B. WING _____	R-C 06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOONER STATION AT UNIVERSITY NORTH PA	2803 24TH AVENUE NW NORMAN, OK 73069

(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
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 06/23/25. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE