

Delivery via email to: soonerstationed@islllc.com; midean@soonerstationsl.com

January 23, 2026

License Number: AL1415

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

RE: Survey Event ID: 35DI11

Dear Mr. Dean:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **January 21, 2026**. No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Respectfully,

Clorissa Nubine

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

Enclosure

INVESTIGATIVE REPORT

Facility: Sooner Station at University North Park

Address: 2803 24th Avenue NW

City, State, Zip: Norman, OK, 73069

Provider #: AL1415

Complaint #: OK00088884

Investigation Date(s): 01/21/26

ALLEGATION(S)

The center failed to ensure call lights were within reach and answered in a timely manner.
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The center failed to ensure a safe, clean, comfortable and homelike environment with supplies available to provide care.
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The center failed to have and/or implement an effective infection control program.
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The center failed to ensure assistance with activities of daily living was provided in a timely manner.

The center failed to ensure care and supervision was provided to prevent falls.

The center failed to ensure residents did not receive unnecessary medications, failed to ensure medications were observed to be administered and not found on the floor and failed to ensure the count of medications was accurate.

An unannounced on-site investigation was initiated 01/21/2026 at 9:05 a.m.

A sample of nine residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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: Upon entrance and throughout the survey resident and staff interaction was observed. Staff were observed assisting residents with activities of daily living. Some residents had private sitters with them for safety. An environmental tour was completed. Storage rooms were locked and contained supplies. Call lights were within resident reach and answered in a timely manner. A medication room and cart were observed and a medication count completed.

Residents stated they received their medication as ordered, staff assisted them with activities of daily living and answered their call light timely. The family stated residents' rooms and common areas were clean and comfortable. The staff stated every two-hour resident checks were completed for care and safety.

Policies and procedures, resident assessments, resident care plans, physician orders, medication administration records, medication count records, incident reports, progress notes, infection control log, grievances, and resident council minutes were reviewed.

The attached CMS 2567 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: 01/22/2026

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/21/2026
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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 complaint investigation (#OK00088884) was conducted on 01/21/26. No deficiencies were cited. Facility Census: 92	C 000		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE