STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175558	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Leawood - Iron Horse Hlth	5401 W 143rd Street Leawood, KS 66224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 59 residents with a census of 28 residents on the East unit. Based on observation, record review, and interviews, the facility failed to prevent two Certified Nurse Aides (CNAs) from bringing weapons into the facility and further failed to prevent gun violence between the two CNAs on the East unit. On 02/10/26 at approximately 03:28 AM, CNA M went down the Northeast (NE) corridor and unlocked the door that led to an exit outside. He then walked back down the hallway towards the nurses' station, pulled a gun out of his jacket, and fired multiple shots into the dining room where CNA N was located. CNA N returned an unknown number of rounds down the East Hall, where nine residents resided, with a bullet grazing the wall next to Resident (R) 2's room and a bullet, possibly the same one, hitting the doorframe of R1's room. CNA M ran down the NE hall and out of the NE corridor door while CNA N remained in the facility until law enforcement arrived. This deficient practice placed the residents in immediate jeopardy. Findings included:- In a written statement on 02/10/26, CNA R stated at 03:20 AM, she heard three popping sounds on the East unit, and she ran over to see what happened. She stated she saw smoke and saw three gun shell casings on the ground in front of the nurses' station. She heard CNA N yell to call 911 twice and Licensed Nurse (LN) G went with her back to the [NAME] unit to call 911. CNA R stated the police showed up and she told them the incident was on the East unit. She then checked all of her rooms to make sure the residents were safe. In a written statement on 02/10/26, LN G stated around 03:20 AM, she was taking a break in the activity room when she heard someone screaming then she heard gun shots. She said she went towards the East unit when CNA R said there were gun shells on the floor and to call the police. LN G stated she immediately ran back to the [NAME] unit and called 911. She called the clinical on-call and informed her about the gun shots and that police were in the building. LN G stated she checked on the residents to make sure they were okay. On 02/11/26 at 09:20 AM, an observation of the East Hall revealed a round indentation on the lower part of R1's door frame. There was a bullet graze mark in the middle section of the wall, approximately four to six inches in length, near R2's room. In the dining room, directly across from the East Hall, there were two bullet holes in the window and two to three bullet holes in the wall. On 02/11/26 at 09:30 AM, Administrative Staff A pulled up video surveillance from the NE corridor camera. The video, no date/time stamp located on the video, revealed CNA M walked down the NE hallway to unlock the NE corridor door. He walked back up the NE hallway towards the nurses' station, reached into his jacket, turned towards the dining room, lifted his arm up, and shot an unknown number of rounds into the dining room. CNA M then ran back down the NE hallway and out of the NE corridor door. CNA O walked from behind the nurses' station and looked down the NE hallway. On 02/11/26 at 10:17 AM, R1 sat in his wheelchair in his room. He said, in regard to the shooting incident on 02/10/26, he heard what he thought were pots and pans clanging around and that initially woke him up. He stated he then heard three to four shots and one of them hit his door frame. R1 stated when the bullet hit his doorframe, he thought the shooter was coming into his room for him but denied being scared. He stated the facility had a psychologist visit with him yesterday and he slept good last night. On 02/11/26 at 10:25 AM, R2 sat in his wheelchair in his room (continued on next page)

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.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	and watched television. He said, in regard to the shooting incident on 02/10/26, he heard gunshots which startled him awake and he was scared for a few seconds. R2 stated he felt like the facility handled the situation. On 02/11/26 at 09:12 AM, Administrative Staff A stated on 02/10/26 after 03:30 AM, he received a call that at approximately 03:29 AM, there were shots fired in the facility and the police showed up within five to six minutes. He stated CNA M had fled the facility and police searched for him and CNA N remained at the facility. Administrative Staff A stated both CNA M and CNA N had guns and CNA N stated he had an uneasy feeling about CNA M earlier in the shift and went out to his car to bring his gun in. Administrative Staff A stated CNA N did not report the uneasy feeling to anybody prior to the incident. He stated CNA M unlocked the door then fired off some shots and CNA N must have returned fire. Administrative Staff A stated the police took the staff down to the station to interview them, so he had not had a chance to interview the staff yet. He stated the facility brought in grief counseling for the residents and staff, hired a nighttime security guard, and started staff education. Administrative Staff A stated all of CNA M's shots were to an outside wall, while CNA N's went down the hallway. On 02/11/26 at 09:37 AM, Administrative Staff A said the facility brought in a grief counselor and had the employee assistance program ([NAME]) open to staff because the staff were pretty shaken up. He said the facility notified all of the residents' representatives and the facility had a town hall meeting with residents on 02/10/26 to go over any concerns. Administrative Staff A stated the residents brought up that they wanted increased security. He stated the facility hired a nighttime security guard. On 02/11/26 at 11:20 AM, Administrative Staff B stated the facility started education with staff on workplace violence, reporting protocols, security and access control, emergency response, active shooter, antiharassment and antiretaliation, and technology and social media controls. He stated the facility offered support directly for employees and provided [NAME] for ongoing counseling. He stated the facility put a security guard in place for nights and a psychologist visited with residents. On 02/11/26 at 12:01 PM, LN H said if there was an active shooter in the facility, she made sure she and everyone was safe. She stated no residents had voiced any concerns about being scared after the incident. On 02/11/26 at 12:03 PM, CNA P said if there was an active shooter in the facility, she took care of the residents and closed all of the doors. On 02/11/26 at 12:04 PM, CNA Q said if there was an active shooter in the facility, she closed all of the residents' doors and she received education on 02/10/26 on workplace violence. On 02/11/26 at 02:11 PM, Administrative Staff A stated the facility's active shooter procedure was to run, hide if you can, and fight. He stated staff were to save the residents if they could. Administrative Staff A stated CNA N stated he felt threatened by CNA M earlier in the shift and he went out to get his gun. He stated he was unaware of any problems between CNA M and CNA N prior to the incident. On 02/12/26 at 10:40 AM, LN I stated on 02/10/26 before the shooting incident at approximately 03:30 AM, she saw CNA M and CNA N exchange words then CNA M went back to the [NAME] unit. She stated CNA N left the facility around 01:00 AM or 02:00 AM and when he came back, he sat in the dining area, which he never did. LN I stated she was down on the Southeast Hall when CNA M walked towards CNA N and they exchanged words over Certified Medication Aide (CMA) S. She stated CNA M walked off like he was leaving the unit but instead of continuing straight, he turned right onto the NE Hall then turned back. LN I stated she saw CNA M peek around the corner towards the dining room then he started firing shots. She said she saw flashing lights then heard gunshots and went into an empty room. LN I heard CNA O scream, and she thought CNA O had gotten shot. LN I stated she heard four shots then one single shot and she saw CNA M exit the NE corridor door. She stated CNA N and CNA O went to the room she was in and she called the police. She told police they did not know where CNA M was, but CNA N was still on the premises and had a gun that was registered to him. LN I stated when police arrived, CNA N placed the gun on the ground, and they took him into custody. On 02/12/26 at 01:57 PM, CNA O stated on 02/10/26, she sat at the nurses' station by herself on the East Unit. She stated CNA M worked on the [NAME] Unit and he came over to the East Unit to get snacks but then he and CNA N, who sat in the dining room, started arguing. She could not hear what the conversation (continued on next page)

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