State of Tennessee
Health Facilities Commission
Andrew Jackson State Building
502 Deaderick Street, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

May 18, 2026 Sent Via Email

Karen Leach (karenleach@therastaffing.com)
TheraStaffing, LLC
4860 Hickory Creek Rd
Lenoir City, TN 37771

Facility Type: Home Health Agencies
License Number: 712

Dear Karen Leach:

It is my pleasure to inform you that your application for licensure of TheraStaffing, LLC located at 4860 Hickory Creek Rd, Lenoir City, TN 37771 has been initially approved effective May 18, 2026. The license number shall be 712. For this initial approval to become final and permanent, your application must be ratified by the Commission pursuant to T.C.A. §68-11-206. The Commission will consider your application at its next meeting, scheduled for June 24, 2026. **You are hereby authorized to commence operation pending the final decision of the Commission**.

For certification purposes, please be advised it is your responsibility to contact your Health Facilities Commission regional office for participation in Medicare/Medicaid. The East Tennessee Regional Office phone number is 865-594-9396 .

If the Commission **does** ratify the approval of your application, the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) business days; notifying you of the Commission's final decision.

If the Commission **does not** ratify the initial approval of your application, a letter will be forwarded to you providing an explanation and specific instructions as to any action(s) you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

Please contact me if I can be of further assistance.

Sincerely,
Eddie J. Stewart
Eddie J. Stewart
Health Facilities Program Manager
Health Facilities Commission
Licensure and Regulation Unit

cc: East Tennessee Regional Office

Application Summary

Application Detail

License Type:	**Home Health Services: Licensed**
Application:	**Home Health Services: Initial Application**
Application Date:	**09/25/2025 (mm/dd/yyyy)**

Organization Detail

Organization Name:	**TheraStaffing, LLC**
Organization Type:	**Limited Liability Company**

Addresses

Mailing Address

Address:	**4860 Hickory Creek Rd**
	LOUDON
	Lenoir City, TN
	37771
	US
Phone Number:	**865-660-1202**
Extension:	
E-mail Address:	**karenleach@therastaffing.com**

Administrative

Name:	**TheraStaffing, LLC**
Address:	**4860 Hickory Creek Rd**
	LOUDON
	Lenoir City, TN
	37771
	US
Phone Number:	**865-660-1202**
Extension:	
E-mail Address:	**karenleach@therastaffing.com**

Emergency Contact

Name:	**TheraStaffing, LLC**
Address:	**4860 Hickory Creek Rd** **LOUDON** **Lenoir City, TN** **37771** **US**
Phone Number:	**865-660-1203**
Extension:	
E-mail Address:	**kentleach@therastaffing.com**

Ownership of Building

Name:	**Kent Leach**
Address:	**4860 Hickory Creek Rd** **LOUDON** **Lenoir City, TN** **37771** **US**
Phone Number:	**865-660-1203**
Extension:	
E-mail Address:	**kentleach@therastaffing.com**

Legal Entity

Name:	**TheraStaffing, LLC**
Address:	**4860 Hickory Creek Rd** **LOUDON** **Lenoir City, TN** **37771** **US**
Phone Number:	**865-660-1202**

Extension:	
E-mail Address:	**kentleach@therastaffing.com**

License Attributes Selected

Specialty	**Home Health Agency**
	Limited to EEOICPA
	Occupational Therapy
	Physical Therapy
	Speech Therapy
Qualification/Certification	**EEOICPA-Anderson**
	EEOICPA-Blount
	EEOICPA-Bradley
	EEOICPA-Campbell
	EEOICPA-Claiborn
	EEOICPA-Cumberland
	EEOICPA-Knox
	EEOICPA-Loudon
	EEOICPA-Meigs
	EEOICPA-Monroe
	EEOICPA-Morgan
	EEOICPA-Rhea
	EEOICPA-Roane
	EEOICPA-Scott
	EEOICPA-Sevier
	EEOICPA-Union

Basic License Data

Do you have Branch Offices? If yes, enter number(s) of branch(es).	**no**

Provide Administrator's Name:	**Karen Leach**
Provide the Ownership's Name:	**Kent Leach**
Is your facility accredited by a federally approved accrediting body?	**No**
What type of Home Care Organization: Hospital Based or Nursing Home Based or Free Standing?	**Free Standing**
Provide a Yes or No, if your facility is Chain Affiliated	**No**
Provide a Yes or No, if your facility has a Holding Company	**No**
Provide a Yes or No, if your facility has a Parent Company	**No**
Do you have Other Licensed Facilities in the state of Tennessee and/or other states?	**No**
Do you have a contract with a management firm to operate this facility?	**No**
Have any owners ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state?	**No**
Provide a Yes or No, Do you provide services to a pediatric population?	**No**
Provide a Yes or No, Is your agency a provider in the EEOICPA federal program?	**Yes**

Administrator's Conviction Information

Administrator convicted of crime?:	**No**

Individual Owners, Partners, Director or Head of Government Entity 1

The name of the individual owner, partner, director of the corporation or head of the government:	**R. Kent Leach**
Street:	**4860 Hickory Creek Rd**
City:	**Lenoir City**
State:	**Tennessee**
Zip:	**37771**

Individual Owners, Partners, Director or Head of Government Entity 2

The name of the individual owner, partner, director of the corporation or head of the government:	**Karen J. Leach**
Street:	**4860 Hickory Creek Rd**
City:	**Lenoir City**
State:	**Tennessee**
Zip:	**37771**

Owner Discipline Information

Have any of the owners of the disclosing entity ever been denied a license suspended or revoked?:	**No**
Have any of owners of the disclosing entity had a suspension of admissions?:	**No**
Have any of the owners of the disclosing entity paid any civil monetary penalties for a health care facility in Tennessee or any other state?:	**No**

File Attachments

TheraStaffing_Exemption-2025.pdf

TheraStaffing Bank Statement.pdf

Fees

Initial License Fee	**$1404.00**
Total Amount Due:	**$1404.00**

Attestation

I, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a Home Health Services facility in the State of Tennessee. I HEREBY: SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview. RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Home Health Services facility. AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications. RELEASE from liability the Board, its staff, and all their representatives and any

and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification. ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary. This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

HFC

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: Home Health License # (if applicable): _____ County: Loudon

Initial ✓ Renovation _____ Satellite/Off Campus Location _____

Physical Plant/Services/New Addition _____ Relocation/Replacement Facility _____
(Circle One) (Circle One)

Facility Name: TheraStaffing

Address: 4860 Hickory Creek Rd City: Lenoir City Zip Code: 37771

Application and fee on file in Central Office (CO)?: Yes ✓ No ____ CON #: _____

Project #: _____ Phase: _____ of _____

Facility approved for (if satellite/off campus site include address): EEO/CPA
OT, PT, ST Anderson, Blount, Bradley, Campbell, Claiborne, Cumberland, Knox, Loudon, Meigs, Monroe, Morgan, Rhea, Roane, Scott, Sevier, Union

Sprinklered: _____ (Full 100%) Partial: ✓ (%)

Licensed bed count from: NA to _____ Number of beds increased/decreased: _____

Total Licensed bed count: _____

If secured unit, number of beds in unit: _____ If Alzheimer's unit, number of beds in unit: _____
(NOTE: If this is an increase in the number of beds in a secured Alzheimer's unit, indicate number of beds approved for the increase number only)

Health Surveyor: _____ Date: 5/14/2026

Fire Safety: _____ Date: _____

CD Approved: Yes____ No____ N/A____

Health Survey Required: Yes ✓ No ____; if Yes, please indicate which region: ETRO

Facility's Letter of Notification received in Licensure: Yes ____ No ____
(Completed by Central Office Licensure Staff)

CMS Paperwork (855, etc) approved and received in regional office: Yes ____ No X
(NOTE: With exception of Initial Licensure Approvals)

Effective date: 5/18/2026

Licensure is recommended: Yes X No ____
(Completed by Central Office Licensure Staff)

Don Lane, RN / JL. 5/15/2026
Regional Administrator/Facilities Construction Director or Designee Date

Eddie Stewart 5/18/2026
Licensure Program Unit Staff Date

State of Tennessee
Health Facilities Commission
502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-2364 hsda.staff@tn.gov

INITIAL NOTIFICATION OF HOME HEALTH ACCREDITATION FOR CON EXEMPTION

Instructions: This form must be filed with the Health Facilities Commission by any person who intends to establish a health care institution or initiates any service specified in T.C.A. 68-11-1607 (a) (3) pursuant to the exemption provided in T.C.A. 68-11-1607 (r) or T.C.A. 68-11-1607 (r) This form must be emailed to hsda.staff@tn.gov.

1. **REPORTING DATE:** September 25, 2025

2. **NAME AND ADDRESS OF PROVIDER**

TheraStaffing, LLC
Name

P.O. Box 5285
Address

Oak Ridge | TN | 37831
City | **State** | **Zip**

3. **CONTACT PERSON OR AUTHORIZED AGENT REPORTING EXEMPTION**

R. Kent Leach | Owner
Name | **Title**

kentleach@therastaffing.com
Email Address

TheraStaffing, LLC
Company Name

4860 Hickory Creek Rd
Address

Lenoir City | TN | 37771
City | **State** | **Zip**

865-660-1203	865-635-4662
Phone Number	**Fax Number**

4. **IF SEEKING THE ESTABLISHMENT OF A HOME HEALTH AGENCY UNDER EXEMPTION, DATE OF LICENSE SUBMISSION:**

9-25-2025

5. **IF CURRENTLY LICENSED, PROVIDE LICENSE #:**

N/A

LIST CURRENT LICENSED COUNTIES:

N/A

COUNTIES LICENSED UNDER EEOICPA:

Anderson, Roane, Morgan, Campbell, Claiborne, Knox, Blount, Loudon, Monroe
Fentress, Union, McMinn, Meigs, Bradley, Scott

COUNTIES LICENSED UNDER PEDIATRIC

N/A

COUNTIES LICENSED AS HOME INFUSION ONLY:

N/A

LIST ANY EXISTING CERTIFICATE OF NEED LIMITATIONS/CONDITIONS:

N/A

6. **DESCRIPTION OF EXEMPTED ACTIVITY:**

Rehab Services (Physical, Occupational, Speech Therapy) Home Health Agency serving only EEOICPA patients

LIST OF EXEMPTED COUNTIES TO BE ADDED UNDER THE FOLLOWING TYPES:

PEDIATRIC:

EEOICPA:

Anderson, Roane, Morgan, Campbell, Claiborne, Knox, Blount, Loudon, Monroe,
Fentress, Union, McMinn, Meigs, Bradley, Scott

7. NAME AND ADDRESS OF PROVIDER

TheraStaffing, LLC
Name

4850 Hickory Creek Rd
Address

Lenoir City	TN	37771
City	**State**	**Zip**

8. ACCREDITATION (must be completed within 2 years of initial licensure)

Please Check
(Be advised that some accreditation organizations require 10 or more patients at a minimum before starting accreditation proceedings.)

- ☐ Community Health Accreditation Program, Inc.
- ☐ Accreditation Commission for Health Care and/or other accrediting body with deeming authority for home health services from CMS and participation in the Medicare Quality Initiatives
- ☐ Outcome and Assessment Information Set, and Home Health Compare, or other nationally recognized accrediting organization, for Home Health projects;

I UNDERSTAND THAT A HOME HEALTH AGENCY THAT PROVIDES HOME HEALTH SERVICES WITHOUT A CERTIFICATE OF NEED TO PEDIATRIC AND/OR EEOICPA PATIENTS THAT FAILS TO COMPLY WITH THE ACCREDITATION REQUIREMENTS IS SUBJECT TO LICENSURE SANCTIONS.

R. Kent Leach 9-25-2025
Signature **Date**

R. Kent Leach
Printed Name

THERASTAFFING, LLC

Entity Type: Limited Liability Company (LLC)
Formed in: TENNESSEE
Term of Duration: Perpetual
Managed By: Member Managed
Series LLC: No
Number of Members: 6 or less

Status: Active
Control Number: 000799350
Initial Filing Date: 5/11/2015 4:28:50 PM
Fiscal Ending Month: December
AR Due Date: 04/01/2027
Obligated Member Entity: No

Registered Agent

RODNEY KENT LEACH
4860 HICKORY CREEK RD
LENOIR CITY, TN 37771

Principal Office Address

4860 HICKORY CREEK RD
LENOIR CITY, TN 37771-6964

Mailing Address

4860 HICKORY CREEK RD
LENOIR CITY, TN 37771-6964

AR Standing: Good | RA Standing: Good | Other Standing: Good | Revenue Standing: Good

History (14)