Application Summary

 F-1600 ETRO/TASD App#24126

Application Detail

License Type:	**Home Medical Equipment: Licensed**
Application:	**Home Medical Equipment: Initial Application**
Application Date:	**07/15/2026 (mm/dd/yyyy)**

Organization Detail

Organization Name:	**Prism Medical Products, LLC** LLC.

Addresses

Main Address

Address:	**112 Church Street** **Suite 101** **SURRY** **Elkin, NC** **28621** **US**
Phone Number:	**888-244-6421**
Extension:	**4373**
E-mail Address:	**compliance@prism-medical.com**

Administrative

Name:	**Prism Medical Products, LLC**
Address:	**112 Church Street** **Suite 101** **SURRY** **Elkin, NC** **28621** **US**
Phone Number:	**888-244-6421**
Extension:	**4373**

E-mail Address:	**compliance@prism-medical.com**

Emergency Contact

Name:	**Prism Medical Products, LLC**
Address:	**112 Church Street** **Suite 101** **SURRY** **Elkin, NC** **28621** **US**
Phone Number:	**888-244-6421**
Extension:	**4373**
E-mail Address:	**compliance@prism-medical.com**

Ownership of Building

Name:	**The Bonanza Group, LLC**
Address:	**128B W Main Street** **Suite 201** **SURRY** **Elkin, NC** **28621** **US**
Phone Number:	**336-258-2576**
Extension:	
E-mail Address:	**info@bonanzagrouponline.com**

Legal Entity

Name:	**Prism Medical Products, LLC**
Address:	**112 Church Street** **Suite 101** **SURRY**

	Elkin, NC
	28621
	US
Phone Number:	**888-244-6421**
Extension:	**4373**
E-mail Address:	**compliance@prism-medical.com**

Parent Company

Name:	**Henry Schein Home Health, LLC**
Address:	**135 Duryea Road**
	SUFFOLK
	Melville, NY
	11747
	US
Phone Number:	**888-244-6421**
Extension:	
E-mail Address:	**compliance@prism-medical.com**

License Attributes Selected

Qualification/Certification	**All Counties**
Additional License Information	**For Profit**

(verified 7/18/26 CNS) Out of State North Carolina

Basic License Data

If your facility has branch offices provide the number. If none, enter 00	**00**
Provide Administrator's Name:	**James St. Cyr**
Provide the Ownership's Name:	**Prism Medical Products, LLC**
Is your facility accredited by a federally approved accrediting body?	**Yes**
If answered yes accredited, must provide expiration date of accreditation.	**10/28/2028 (mm/dd/yyyy)**

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**
Do you have Other Licensed Facilities in the state of Tennessee and/or other states?	**Yes**
Provide a Yes or No, if your facility has a parent company:	**Yes**
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**
Does your facility have a physical location in Tennessee?:	**No**

Administrator Conviction Information

Administrator convicted of crime?:	**No**

Individual Owners, Partners, Director or Head of Government Entity

The name of the individual owner, partner, director of the corporation or head of the government:	**James St. Cyr**
Street:	**112 Church Street, Suite 101**
City:	**Elkin**
State:	**North Carolina**
Zip:	**28621**

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	**No**

health care facility in Tennessee or any other state?:

File Attachments

01.2026 Bank Statement-Redacted.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 Medical Equipment 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 Medical Equipment 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.

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

September 18, 2026 Sent Via Email

James St. Cyr
Prism Medical Products, LLC
112 Church Street, Suite 101
Elkin, North Carolina 28621

Facility Type: Home Medical Equipment

Dear James St. Cyr:

It is my pleasure to inform you that your application for licensure of Prism Medical Products, LLC located at 112 Church Street, Elkin, North Carolina 28621 has been initially approved for providing DME/HME services in all counties in Tennessee effective September 18, 2026 . The license number shall be 1600. 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 . **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,

Niraj Soni

Niraj Soni, ASA 3
Phone: (615) 741-7539
Fax: (615) 253-8798
Email: Niraj.Soni@tn.gov

HFC

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): 1600 County: Surry

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Prism Medical Products 112 Church Street Suite 101 Elkin N.C. 28621

Application and fee on file in Central Office (CO)? Yes X No CON #: Project #: Phase: _____ of __

Facility approved for Home Medical Equipment (HME): Providing DME/HME services in all counties in Tennessee.

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

Licensed bed count from: 0 to 0 Number of beds increased/decreased: 0

If secured unit, number of beds in unit: N/A 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: Nancy Mullins RN Date: 09/17/26

Fire Safety: See attached application Date: _____

CD Approved: Yes ___ No ___ N/A x Health Survey Required: Yes X No ___; if Yes, please indicate which region: EAST

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

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

Effective date: September 18 2026 Licensure is recommended: Yes X No ___
(Completed by Central Office Licensure Staff)

Debra Vann HCT 9/18/2026
Regional Administrator/Facilities Construction Director or Designee Date

Virgil S 9/18/26
Licensure Program Unit Staff Date

Prism Medical Products, LLC

Elkin, NC

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

October 18, 2025

Accreditation is customarily valid for up to 36 months.

Michael Suk, MD, JD, MPH, MBA, FACS
Chair, Board of Commissioners

ID #469864
Print/Reprint Date: 10/21/2025

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

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