STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967694	**06/20/2017**
NAME OF PROVIDER OR SUPPLIER **SHARING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **2897 HARSON WY** **FORT PIERCE, FL 34946**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Limited Nursing Services monitoring survey was conducted on 6/20/17 at Sharing Facility, (license #11722). The facility had no deficiencies at the time of the visit.