

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969325	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/09/2025
NAME OF PROVIDER OR SUPPLIER CAPITAL SQUARE AT TALLAHASSEE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1060 CLARITY POINTE TALLAHASSEE, FL 32308		
(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	
A 000	Initial Comments An unannounced complaint survey for complaints 2025010962 and 2025014914 was conducted on 10/9/2025 at Capital Square At Tallahassee Assisted Living and Memory Care, an assisted living facility in Tallahassee, FL. At the time of the survey, the facility was in compliance with the requirements for Assisted Living Facilities. No deficient practice was cited.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE