

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 01/13/2026
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 complaint numbers 2025017516 and 2025017711 was conducted in conjunction with a revisit survey at Capital Square At Tallahassee Assisted Living and Memory Care in Tallahassee, FL on January 12-13, 2026. The facility had no deficient practice at the time of the investigation.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE