

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 03/03/2026
NAME OF PROVIDER OR SUPPLIER CAPITAL SQUARE AT TALLAHASSEE ASSISTE			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 #2026002858 was conducted on March 3, 2026 at Capital Square At Tallahassee Assisted and Memory Care 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

(X6) DATE