Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

June 17, 2026

[redacted], OWNER/ADMINISTRATOR
WILMATT INC
[redacted]

RE: MCCALLUM ASSISTED LIFE
7141 MCCALLUM STREET
PHILADELPHIA, PA, 19119
LICENSE/COC#: 14445

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/23/2026, 04/24/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MCCALLUM ASSISTED LIFE* **License #**: *14445* **License Expiration**: *07/31/2026*

Address: *7141 MCCALLUM STREET, PHILADELPHIA, PA 19119*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *WILMATT INC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-3 SP* **Date**: *02/20/1991* **Issued By**: *City of Phila.*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *34* **Waking Staff**: *26*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *04/24/2026*

Inspection Dates and Department Representative

04/23/2026 - On-Site: [redacted]

04/24/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *31*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *26*

Diagnosed with Mental Illness: *20* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *3* **Have Physical Disability**: *1*

Inspections / Reviews

04/23/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/28/2026*

06/03/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/08/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/08/2026*

Inspections / Reviews *(continued)*

06/17/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/08/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Per fire safety letter dated 03/23/26. There were deficiencies noted and remain uncorrected:
-The third floor center stairwell does not have a latching hardware on the door.
-There is not a hallway smoke detector located within 15 feet of the resident rooms #300, #301, #302 and #306.
-The fire rating tag for the third-floor stairwell fire door by room #306 is painted over and not legible.
-The fire extinguisher in the home do not have the 30-day inspections listed on the fire extinguisher inspection tag.
-The center stairwell hand railing is loose and unsteady between the first and second floors in the center stairwell.
-There is not a visible exit sign upon exiting room #107 and traveling to the left towards the nurse's station.
-There is a penetration in the ceiling around the sprinkler head in the first-floor phone booth as the sprinkler head is missing the escutcheon plate.
-There is a penetration around the sprinkler head in the main kitchen pantry.
-There is a penetration in the ceiling in the basement center stairwell.
-The kitchen Ansul fire suppression system is past due for professional inspection.
-The carbon monoxide detector in the boiler room is due for battery replacement, and the date of battery installation should be listed on the batteries/detector.
-The stairwell door across from room #107 does not close and latch as it being held open with an allen wrench.
-The fire rated door of the maintenance/housekeeping area in the basement does not close at latch without assistance.
-There are multiple ceiling tiles missing and penetrations in the ceiling and walls of basement service hallway and storage areas.
-The inspection tag on the wet sprinkler system indicates that the annual inspection was due in October 2025. There are stored items partially obstructed access to the sprinkler controls.
-The fire extinguisher in the electrical room storage room in the service hallway is not properly mounted.
-There are wires resting on the sprinkler piping in the electrical room/storage room in the basement service hallway.
-The emergency lighting in the basement service hallway electrical/storage room did not function upon testing.

Plan of Correction ***Accept ([redacted] - 06/03/2026)***

The community received the fire safety report in the first week of April. New maintenance man was hired [redacted] and after training started making repairs. Several of the items are from upgrades to the sprinkler system that was approved by the owner in November 2025. Permit application notice was received from the city of Philadelphia January 17, 2026, and the community is waiting on final approval and scheduling from the company making the repairs.
Immediate: (4/27/26) Community maintenance man continues to make necessary repairs.
Training: (5/18/26) Maintenance was trained to do a community walk through to look for necessary repairs.
How trained: Inservice by Administrator using Regulatory Compliance Guide
Responsible Staff: Maintenance
On-Going: (5/25/26) Maintenance will do a weekly community walk through using a checklist in addition to completing repairs from fire safety report.

Licensee's Proposed Overall Completion Date: *06/06/2026*

18 - Compliance With Laws *(continued)*

Implemented (- 06/15/2026)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A, hired on did not have a current Pennsylvania criminal background check completed.

Plan of Correction ***Accept (- 06/03/2026)***

Staff Member A was an employee for our sister community and has worked at both communities over the years. We used file from the sister community which we thought was acceptable since worked for us for five years.
Immediate: (5/5/26) Administrator completed a new employee file with Staff Member A.
Training: (5/18/26) Administrator was trained to make sure criminal background is completed for all new employees.
On-going (5/25/26) Administrator will review staff records monthly using a checklist.
How trained: Inservice by Owner using Regulatory Compliance Guide
Responsible Staff: Administrator

Licensee's Proposed Overall Completion Date: *06/05/2026*

Implemented (- 06/15/2026)

65a - FS Orientation 1st Day

3. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was , did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

65a - FS Orientation 1st Day *(continued)*

Plan of Correction ***Accept (- 06/03/2026)***

Staff Member A was an employee for our sister community and has worked at both communities over the years. We used file from the sister community which we thought was acceptable since worked for us for five years.
Immediate: (5/18/26) Administrator completed new employee file with all required orientations.
Training: (5/18/26) Administrator was trained to make sure 1st day orientation is completed for all new employees.
How trained: Inservice by Owner using Regulatory Compliance Guide
Responsible Staff: Administrator
On-going (5/25/26) Administrator will review staff records monthly using a checklist.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented (- 06/15/2026)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed 40th scheduled work hour on However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Plan of Correction ***Accept (- 06/03/2026)***

Staff Member A was an employee for our sister community and has worked at both communities over the years. We used file from the sister community which we thought was acceptable since worked for us for five years.
Immediate: (5/5/26) RCC completed new employee file with all required orientations.
Training: (5/18/26) Administrator was trained to make sure 1st day orientation and all other rights/abuse trainings in first 40 hours of scheduled working hours is completed for all new employees.
How trained: Inservice by Owner using Regulatory Compliance Guide
Responsible Staff: Administrator
On-going (5/25/26) Administrator will review staff records monthly using a checklist.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented (- 06/15/2026)

85a - Sanitary Conditions

5. Requirements

2600.

85a - Sanitary Conditions *(continued)*

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 04/23/26, at approximately 10:30 am, the bathtub in the third-floor bathroom near room #306 had a black substance on it that appears to be mold.

Plan of Correction ***Accept (- 06/03/2026)***

Immediate: (5/5/26) Bathroom near room 306 was cleaned. Tub is worn out, not dirty, and will be repaired with a ceramic coating.
Training: (5/18/26)) Administrator trained housekeepers on cleaning properly and to notify administrator if worn out.
How trained: Inservice by Administrator using Regulatory Compliance Guide.
Responsible Staff: Housekeeping
On-going: (5/25/26) Administrator will do a walk-through monthly using a checklist.
Update: (5/28/26) Maintenance place a ceramic coating on the tub.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented (- 06/15/2026)

100a - Exterior - Free of Hazards

6. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 04/23/36, at approximately 11:00 am, there were leaves on the landing and steps of the two exits from the basement.

Plan of Correction ***Accept (- 06/03/2026)***

Immediate: (4/24/26) Housekeeper cleared leaves from steps of landing from the two basement exits.
Training: (5/18/26) The Administrator trained maintenance/housekeeping staff to walk the grounds and notify management and maintenance of any issues with exterior hazards.
How trained: Inservice by Administrator using Regulatory Compliance Guide.
Responsible Staff: Maintenance/Housekeeping
On-Going: (5/25/26) Maintenance will do a weekly community walk through using a checklist

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented (- 06/15/2026)

103i - Outdated Food

7. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There were unlabeled, undated potato tots, chicken patties, and French fries in the freezer.
There was an unlabeled, undated bag of brown sugar in the food pantry.

103i - Outdated Food *(continued)*

Plan of Correction ***Accept (- 06/03/2026)***

Immediate: (4/23/26) All outdated food was thrown out.
Training: (5/18/26) The Cook was trained to make sure all outdated food is disposed of.
How trained: Inservice by Administrator using Regulatory Compliance Guide.
Responsible Staff: Cook
On-going: (5/18/26) Administrator will do a walk-through monthly using a checklist.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented (- 06/15/2026)

132e - Fire Drill Sleeping Hours

8. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on April 25, 2025, at 11:45 pm.

Plan of Correction ***Accept (- 06/03/2026)***

Immediate: (4/24/26) Fire drill for May was scheduled for sleeping hours.
Training: (5/18/26) Administrator was trained to conduct fire drills during overnight hours every six months.
How trained: Inservice by Owner using Regulatory Compliance Guide.
Responsible Staff: Administrator
On-going: (5/22/26) Owner will confirm overnight drill in fire drill log with a check mark.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented (- 06/15/2026)

182b - Prescription Medication

9. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 4/01/26, 4/02/26, and 4/03/26, at 8:00 am, staff person A administered medications to resident #1 to include the following; Insulin Lisp Inj 100/ml, Fluphenazine Tab 2.5 mg, Metformin Tab 100 mg, Gabapentin Cap 100 mg,

182b - Prescription Medication (continued)

Pantoprazole Tab 40 mg, Propranolol Cap 80 mg, Sertraline Tab 50 mg, Tamsulosin Cap 0.4 mg, Benztropine Tab 0.5 mg, Amlodipine Tab 10 mg, Linsinopril Tab 20 mg, Lorazepam Tab 1 mg, and Olanzapine Tab 15 mg. Staff person A is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction ***Accept (- 06/03/2026)***

Staff member A is re-taking the medication management training.
Immediate: (4/24/26) Only staff with the proper documentation will pass medications.
Training: (5/18/26) Owner trained Administrator to follow all regulations for employee certifications using Regulatory Compliance Guide.
How trained: Inservice by Owner
Responsible Staff: Administrator
On-going: (5/25/26) Administrator will audit employee files monthly to ensure compliance using a checklist.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented (- 06/15/2026)

183b - Meds and Syringes Locked

10. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 04/24/26, at approximately 10:35 am, a bottle of Tylenol was unlocked, unattended, and accessible in resident #1's room. Resident #1's medical evaluation dated 02/16/26, indicates resident #1 cannot self-administered medications.

Plan of Correction ***Accept (- 06/03/2026)***

Resident 1 bought Tylenol without the knowledge of the community. Tylenol was removed from the room and resident was educated the need for a doctors order.
Immediate: (4/23/26) We have requested a script from the doctor and for resident 1.
Training: (5/18/26) Housekeeping/Med Techs/Maintenance were trained to report any medications they see in resident rooms to management so they can be removed.
How trained: Inservice by Administrator using Regulatory Compliance Guide
Responsible Staff: Housekeeping/Med Techs/Maintenance
On-going: (5/25/26) Administrator will check the rooms monthly to look for medications residents bring in from the outside using a checklist.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented (- 06/15/2026)

183b - Meds and Syringes Locked *(continued)*

183e - Storing Medications

11. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 04/23/26, resident #2's Insulin Lisp Inj 100/ml pen, with an opening of 12/19/25, was observed in the medication cart. According to the manufacturer's instructions, the insulin pen should be discarded after 30 days of opening.

Plan of Correction ***Accept ([redacted] - 06/03/2026)***

New insulin pen ordered for Resident 2.
Immediate: (4/23/26) Expired pen was discarded. New pen ordered.
Training: (5/18/26) Med Techs were trained by Administrator to discard medications in accordance with manufacturer's instructions using Regulatory Compliance Guide
How trained: Inservice by Administrator using Regulatory Compliance Guide
Responsible Staff: Med Techs
On-going: (5/25/26) Administrator will do random spot checks of carts to make sure expired meds are discarded and opened inhalers are dated. This will be done on various shifts to make sure the staff is complying with the regulations. Checks will be done weekly using a checklist. Community has also reached out to a pharmacy cart auditor to come out to the community monthly based on his availability.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented ([redacted] - 06/15/2026)

185a - Implement Storage Procedures

12. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 is prescribed glucose checks before meals using a sliding scale for additional insulin units based on glucose levels: 200 equals 4 units, 200-250 equals 6 units, 251-300 equals 8 units, and levels over 300 equal 10 units. On 04/23/26, at approximately 6:44 am, resident #1's glucose reading was measured at 246 on the glucometer. The medication administration record was documented as 131.

On 04/18/26, resident #3's Alprazolam Tab 0.5 mg, take one tablet by mouth twice daily, was administered on 04/18/25 at 5:00 pm, as documented on the MAR. However, the narcotic log sheet was not signed.

Plan of Correction ***Accept ([redacted] - 06/03/2026)***

Immediate: (4/24/26) Med Techs were immediately told by administrator to properly document and to follow safe storage/distribution of medications.

185a Implement Storage Procedures (continued)

Training: (5/18/26) Med Techs were trained by administrator to properly document and to follow safe storage/distribution of medications using Regulatory Compliance Guide
How trained: Inservice by Administrator using Regulatory Compliance Guide
Responsible Staff: Med Techs
On Going: (5/25/26) Administrator will do random spot checks of carts, MAR's, and blood sugar logs to make sure glucometers are calibrated, and resident information is being logged correctly. This will be done weekly, on various shifts to make sure the staff is complying with the regulations using a checklist. Community has also reached out to a pharmacy cart auditor to come out to the community monthly based on [redacted] availability.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented ([redacted] - 06/15/2026)

187d - Follow Prescriber's Orders

13. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is prescribed Lorazepam 1 mg tablet, to be taken by mouth every morning at 8:00 am. However, on 04/18/26, resident #1 was administered Lorazepam 1 mg tablet twice at 8:00 am. Both staff person A and B signed the narcotic sheet on 04/18/26 at 8:00 am for the same medication. However, only staff person B signed the medication administration record.

Resident #1 is prescribed Insulin Lispro Inje 100/ML. The dosing instructions are to inject 4 units subcutaneously three times daily before meals, in addition to using a sliding scale for extra units based on glucose levels: under 200 equals 4 units, 200 250 equals 6 units, 251 300 equals 8 units, and levels over 300 equal 10 units.
On 04/23/26, at approximately 6:44 am, resident #1's glucose reading was measured at 246 on the glucometer. The medication administration record was documented as 131. Per sliding scale resident #1 required 6 additional units of insulin; however the resident only received 4 units.

Plan of Correction ***Accept ([redacted] - 06/03/2026)***

Immediate: (4/24/26) Med Techs were immediately told by administrator to properly document and to follow prescribers orders.
Training: (5/18/26) Administrator trained all med techs to follow prescriber's orders.
How trained: Inservice by Administrator using Regulatory Compliance Guide
Responsible Staff: Med Techs
On going: (5/25/26) Administrator will audit Medical Access Records weekly to ensure compliance using a checklist.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented ([redacted] - 06/15/2026)

190b - Insulin Injections

14. Requirements

190b - Insulin Injections *(continued)*

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 04/02/26, 04/09/26, and 04/16/26, at 8:00 am, staff person A administered Ozempic Inj 2mg/3ml to resident #1.
The home does not have a waiver for non-licensed staff to administer GLP-1's.

Plan of Correction ***Accept (- 06/03/2026)***

Family of Resident 1 is reached out to doctor to get an order for the resident to self-administer.
Immediate: (4/30/26) Resident 1 administered the GLP-1.
Training: (5/18/26) Owner trained Administrator on insulin injections regulation
How trained: Inservice by Owner using Regulatory Compliance Guide
Responsible Staff: Administrator
On-Going: (5/25/26) Administrator will look into applying for a waiver for non-licensed staff to administer GLP-1's.

Licensee's Proposed Overall Completion Date: *06/06/2026*

Implemented (- 06/15/2026)