COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: February 25, 2026

Mr. James Ellison, Sr. | CEO
BCL Partners, LLC
911 Gibson Boulevard
Steelton, PA 17113

RE: Leading Youth for Excellence (LYFE)
911 Gibson Boulevard
Steelton, PA 17113
License #: 338170

Dear Mr. Ellison:

The Department of Human Services, Office of Children, Youth and Families ("Department") conducted complaint investigations and monitoring inspections involving Leading Youth for Excellence (LYFE), located at 911 Gibson Boulevard in Steelton, PA 17113 ("LYFE") beginning January 23, 2026, and ending February 23, 2026. During this time, the Department found violations of the Human Services Code and Department regulations.

As a result of violations of 55 Pa. Code Chapter 3800, the Department is REVOKING your License to operate a child residential facility, License Number 338170. The Department's decision to revoke your license is based on the findings contained in Attachment A, demonstrating failure to comply with Department regulations. The facility has created a setting that constitutes gross incompetence, negligence, and misconduct in operating the facility such that a risk to the life and health of the children in care exists. The decision to revoke the license is therefore made pursuant to 62 P.S. §§ 1026(b)(1), (4); and 55 Pa. Code §§ 20.71(a)(1), (2),6) (relating to conditions for denial, nonrenewal or revocation). Each basis for revoking the license serves as an independent basis for the instant revocation action.

If you disagree with the decision to revoke your License Number 338170 you have the right to appeal through a hearing before the department's Bureau of Hearings and Appeals in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas

of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the mailing date of this letter at the following address:

Ms. Gabi Williams,
Central Regional Director
Office of Children, Youth, and Families
Bureau of Children and Family Services
PO Box 2675
HUB Building, 1st Floor
2525 North 7th Street
Harrisburg, PA 17110

This decision is final 11 days from the mailing date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Laval Miller-Wilson, JD
Deputy Secretary
Office of Children, Youth and Families

Enclosure
Findings
Emergency Removal Order

c: Ms. Natalie Bates
Ms. Caitlin Robinson
Ms. Gabi Williams

Pennsylvania
Department of Human Services

February 25, 2026

Via First Class Mail and Certified Mail:

Mr. James Ellison, CEO
BCL Partners, LLC
911 Gibson Blvd
Steelton, PA 17113

RE: Leading Youth for Excellence (LYFE)
911 Gibson Blvd
Steelton, PA 17113
License #: 338170

Dear Mr. Ellison:

Enclosed please find an Order for the Emergency Removal of children from the above-named facility. The children are to be removed as soon as can be safely accomplished but no later than March 2, 2026, at 5:00 PM.

If you disagree with the decision, you have the right to appeal through a hearing before the Department of Human Services' Bureau of Hearings and Appeals in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the department's decision. If you decide to appeal, a written request for an appeal must be received within ten (10) days of the mailing date of this letter at the address below. Please also send an electronic copy of your request via email to me at LMillerWil@pa.gov to ensure timely receipt.

Laval Miller-Wilson
Deputy Secretary
Pennsylvania Department of Human Services
Office of Children, Youth and Families
625 Forster Street
Harrisburg, PA 17120

This decision is final eleven (11) days from the mailing date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Laval Miller-Wilson
Deputy Secretary

Enclosure:
Emergency Removal Order
Findings - Attachment A

ORDER

AND NOW, this 25th day of February 2026, pursuant to 55 Pa. Code § 20.37, the Commonwealth of Pennsylvania, Department of Human Services, hereby determines that the conditions existing at:

Leading Youth For Excellence (LYFE)
911 Gibson Boulavard
Steelton, PA 17113

as described in Attachment A, constitute gross incompetence, negligence and misconduct in operating a facility likely to constitute immediate and serious danger to the life or health of the children in care.

Accordingly, it is hereby ORDERED that all children be removed from the facility as soon as can be safely accomplished given each child's needs but no later than March 2, 2026, at 5:00 PM.

Laval Miller-Wilson, Esq.
Deputy Secretary
Office of Children, Youth, and Families

Attachments:

Attachment A – Findings

Findings

Facility Location: Leading Youth for Excellence (LYFE)
911 Gibson Boulevard
Steelton, PA 17113

Facility License No.: 338170

Legal Entity: BCL Partners, LLC
911 Gibson Boulevard
Steelton, PA 17113

The Department of Human Services, Office of Children, Youth and Families ("Department") conducted complaint investigations and monitoring inspections involving Leading Youth for Excellence (LYFE), located at 911 Gibson Boulevard in Steelton, PA 17113 ("LYFE") beginning January 23, 2026, and ending February 23, 2026. During this time, the Department found violations of the Human Services Code and Department regulations. Based upon the violations and circumstances involving the facility, the Department issued a notice revoking LYFE's License Number #338170.

At the time the Department's revocation notice was issued, LYFE was already on notice that there were multiple physical site concerns to include unsanitary conditions, missing parts of the ceiling, and obstructed egress that required correcting. On February 17, 2026, the Department's representatives took pictures of multiple clogged toilets, standing water in the bathrooms of the facility, a ceiling with missing ceiling tiles, and tables deliberately placed to disallow residents from being able to leave their pods. The Department conducted subsequent visits on February 18, 2026, February 21, 2026, February 22, 2026, and February 23, 2026, and observed that the physical site concerns were still prevalent and staff failed to provide Department representatives with documentation that showed that the facility had submitted maintenance requests to Dauphin County until February 17, 2026. The facility was able to provide documentation of one request that was sent while Department representatives were onsite on Tuesday, February 17, 2026, that only addressed a request for a Pod B sink that was leaking. During an onsite visit on February 23, 2026, the facility provided additional documentation that was sent February 19, 2026. Additionally, while on site on February 23, 2026, Department representatives observed the physical site concerns; all violations of Department regulations at Chapter 3800.

On the above dates, Department representatives observed additional violations related to the health, safety, and well-being of the children in care. Based upon the Department's monitoring, the following violations of 55 Pa. Code Ch. 3800 were observed:

- 3800.16(a)(2): A reportable incident is the following: A physical act by a child to commit suicide.

- During incidents that occurred on 01/01/2026 and 01/02/2026, a resident attempted suicide, and the facility failed to report the incidents to the Department.

- 3800.16(d): The facility shall orally report to the appropriate Departmental regional office and the contracting agency within 12 hours, a fire requiring the relocation of children, an unexpected death of a child and a child who is missing from the facility if police have been notified.
  - During an incident that occurred on 01/26/2026, six (6) residents eloped from the facility, and the facility failed to orally report the elopements to the Department.
- 3800.32(b): A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.
  - During an incident that occurred on 01/16/2026, a resident was pulled out of the control room by the child's arm.
- 3800.32(c): A child has the right to be treated with fairness, dignity and respect.
  - During an incident that occurred on 02/01/2026, a resident was shoved by facility staff.
- 3800.32(k): A child has the right to appropriate medical, behavioral health and dental treatment.
  - During an incident that occurred on 01/01/2026, a resident attempted suicide, and the facility failed to obtain a professional mental health evaluation as a result of the incident.
- 3800.55(a): There shall be one child care worker present with the children for every eight children who are 6 years of age or older, during awake hours.
  - During a review of video footage from an incident that occurred on 01/26/2026 during awake hours, Pod C had 11 residents and 1 staff member present on the pod.
  - While Department representatives were onsite at the facility on 02/17/2026 during awake hours, Pod A had 9 residents and 1 staff member present on the pod.
- 3800.84(a): Sanitary conditions shall be maintained.
  - During physical site walkthroughs by Department representatives on 02/17/2026 and 02/18/2026, it was found that multiple toilets, both in individual rooms and communal bathrooms on the pods, are filled and clogged with unknown items and substances. Toilets and sinks on the pods were observed to be leaking onto the floor of the bathroom while in use. Additionally, hot sauce was found to be spread over the counter of the desk on B-pod and was not cleaned.
  - During a physical site walkthrough by Department representatives on 02/23/2026, urine was observed to be in the sink of Room #10 on Pod A.
- 3800.87(a): Floors, walls, ceilings, windows, doors and other surfaces shall be free of hazards.
  - During physical site walkthroughs by Department representatives on 02/17/2026 and 02/18/2026, the following hazardous conditions were found:
    - Approximately half of the ceiling tiles in Pod B were missing.
    - Wires in the office of Pod B were exposed, causing a safety risk to the residents.
    - The communal bathrooms located on Pod B and Pod C had standing water in the bathroom due to leaking pipes, creating slippery floors.
    - Three separate fire alarm lights were torn from the facility walls, creating exposed wires.

- During a physical site walkthrough by Department representatives on 02/21/2026, the communal bathroom on Pod C had standing water in the bathroom due to leaking pipes, creating slippery floors.

- 3800.121(a): Stairways, hallways, doorways, passageways and egress routes from rooms and from the building shall be unlocked and unobstructed, unless the fire safety approval specified in § 3800.14 (relating to fire safety approval) permits locking of certain means of egress. If fire safety approval is not required in accordance with § 3800.14, means of egress may not be locked.
  - During a physical site walkthrough by Department representatives on 02/17/2026, tables were pushed up against each pod door to prevent residents from leaving the pod and blocking the ability to egress from the area in case of an emergency.
- 3800.141(a): A child shall have a written health and safety assessment within 24 hours
- of admission.
  - The health and safety assessment of a resident did not include a date that the assessment was completed.
- 3800.142: If the health and safety assessment in § 3800.141 (relating to health and safety assessment) identifies a health or safety risk, a written plan to protect the child shall be developed and implemented within 24 hours after the assessment is completed.
  - A resident attempted suicide on 01/01/2026 and 01/02/2026, and a safety plan was not created for this behavior.
  - A resident eloped from the facility on 01/26/2026, and a safety plan was not created for this behavior.
  - Six other residents eloped from the facility on 02/01/2026, and safety plans were not created for this behavior.
- 3800.148(b): Medically necessary physical and behavioral health services, diagnostic services, follow-up examinations and treatment, such as medical, nursing, pharmaceutical, dental, dietary, hearing, vision, blood lead level, psychiatric and psychological services that are planned or prescribed for the child, shall be arranged for or provided.
  - During an incident that occurred on 01/01/2026, a resident attempted suicide, and the facility failed to obtain a professional mental health evaluation as a result of the incident.
- 3800.184(a): A medication log shall be kept to include the following for each child: A list of prescription medications.
  - During a medication record review that occurred on 02/23/2026, the record of one resident included a medication that was discontinued but not removed from the medication administration record.
- 3800.185(a): Documentation of medication errors shall be kept in the medication log. Medication errors include the failure to administer medication, administering the incorrect medication, administering the correct medication in an incorrect dosage or administering the correct medication at the incorrect time.
  - Child A had four prescription medications that were not provided to the resident on 02/17/2026 and 02/23/2026.
  - Child B had a prescription medication that was documented as "O" for omission on 02/11/2026-02/22/2026; there was no documentation of why the medication was omitted. This resident also had another prescription medication that was marked as

"O" for omission on 02/17/2026; there was no documentation of why the medication was omitted.
    - Child C had one prescription medication that was not provided to the resident on 02/17/2026.
    - Child D had two prescription medications that were not provided to the resident on 02/15/2026-02/17/2026.
    - Child E had two prescription medications that were not provided to the resident on 02/17/2026.
    - Child F had one prescription medication that was not provided to the resident on 02/19/2026-02/21/2026.
- 3800.185(b): After each medication error, follow-up action to prevent future medication errors shall be taken and documented.
    - Documentation of follow-up action to prevent future medication errors was not completed by the facility.
- 3800.187(b): Prescription medications and injections shall be administered according to the directions specified by a licensed physician, certified registered nurse practitioner or licensed physician's assistant.
    - Child A had four prescription medications that were not provided to the resident on 02/17/2026 and 02/23/2026.
    - Child C had one medication that was not provided to the resident on 02/17/2026.
    - Child D had two medications that were not provided to the resident on 02/15/2026-02/17/2026.
    - Child E had two medications that were not provided to the resident on 02/17/2026.
    - Child F had one prescription medication that was not provided to the resident on 02/19/2026-02/21/2026.
- 3800.245: A child's record shall be kept in a locked location when unattended.
    - During physical site walkthroughs by Department representatives on 02/17/2026, 02/18/2026, and 02/23/2026 child record information was found to be in an unlocked area and accessible to children.

In addition to the above licensing violations, there are currently five (5) Child Protective Services (CPS) reports and five (5) complaints under investigation. The aforementioned information and licensing violations further demonstrate that the facility is unsuitable to care for children, the facility fails to ensure appropriate medical and mental health treatment to ensure the safety and welfare of children, and the program has failed to institute appropriate programming to aid in the development of children, thereby creating a setting that constitutes gross incompetence, negligence and misconduct in operating the facility likely to constitute immediate and serious danger to the life and health of the children in care pursuant to 55 Pa. Code § 20.37.