COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2013-041

SHARRA BLAKEMORE **APPELLANT**

VS.

FINAL ORDER
SUSTAINING HEARING OFFICER'S
FINDINGS OF FACT, CONCLUSIONS OF LAW
AND RECOMMENDED ORDER

CABINET FOR HEALTH AND FAMILY SERVICES
J.P. HAMM, APPOINTING AUTHORITY **APPELLEE**

** ** ** ** **

The Board at its regular January 2015 meeting having considered the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer dated December 2, 2014, and being duly advised,

IT IS HEREBY ORDERED that the Findings of Fact, Conclusions of Law and Recommended Order of the Hearing Officer be, and they hereby are approved, adopted and incorporated herein by reference as a part of this Order, and the Appellant's appeal is therefore **DISMISSED.**

The parties shall take notice that this Order may be appealed to the Franklin Circuit Court in accordance with KRS 13B.140 and KRS 18A.100.

SO ORDERED this 13th day of January, 2015.

KENTUCKY PERSONNEL BOARD

MARK A. SIPEK, SECRETARY

A copy hereof this day sent to:

Hon. Carrie Cotton
Sharra Blakemore
J. P. Hamm

COMMONWEALTH OF KENTUCKY
PERSONNEL BOARD
APPEAL NO. 2013-041

SHARRA BLAKEMORE **APPELLANT**

V. **FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDED ORDER**

CABINET FOR HEALTH AND FAMILY SERVICES, J. P. HAMM, APPOINTING AUTHORITY **APPELLEE**

** ** ** ** **

This matter came on for an evidentiary hearing on August 28 and 29, 2014, at 9:30 a.m., at 28 Fountain Place, Frankfort, Kentucky, before Mark A. Sipek, Hearing Officer. The proceedings were recorded by audio/video equipment and were authorized by virtue of KRS Chapter 18A.

The Appellant, Sharra Blakemore, was present at the evidentiary hearing and was not represented by legal counsel. The Appellee, Cabinet for Health and Family Services (CHFS), was also present and represented by the Hon. Carrie Cotton. Also present as agency representative was Marian Brooks.

BACKGROUND

1. On February 20, 2013, the Appellant filed an appeal from a three-day suspension she received from her position as a Social Service Clinician I with the Appellee CHFS.

2. The Appellee CHFS issued the Appellant a three-day suspension letter dated December 20, 2012. The Appellee filed a Motion to Dismiss, alleging the Appellant had not filed her appeal in a timely fashion. The Hearing Officer overruled the Motion to Dismiss based on statements the Appellant made at the pre-hearing conference. The Appellant stated that in December 2012 she was on sick leave, and the suspension letter was mailed to her. She was not staying at her home at the time, and is not sure of the exact date she received the suspension letter. Nonetheless, based on the statements the Appellant made, the Appellee did not establish through its motion that the appeal was untimely, and the timeliness issue was passed to the evidentiary hearing.

3. At the outset of the evidentiary hearing, the parties entered into an Agreed Protective Order, because of the fact that there would be testimony and documents concerning clients of the Appellee who were entitled to confidentiality.

4. The issue for evidentiary hearing was whether or not there was just cause for the three-day suspension, and whether that penalty was excessive or erroneous. The burden of proof was upon the Appellee, who presented its case first. The Appellee did not pursue the timeliness issue at the hearing.

5. The Appellee called **Jay Klein** as its first witness. Mr. Klein is the Appointing Authority and the Director of Employee Management.

6. In this instance, Mr. Klein reviewed the Request for Major Disciplinary Action (MDA) he received from the Appellant's region. This request outlined Ms. Blakemore's failure to document home visits in the Cabinet's TWIST system and other failures with respect to cases which were assigned to her. The request for MDA, which was admitted as Appellee's Exhibit 1, was assigned to Jack Barnett, who works in Mr. Klein's division. Mr. Barnett read the request, developed the record further, and reviewed comparable cases of previous disciplinary action.

7. Mr. Barnett prepared a letter of suspension. The letter suspended the Appellant for three days. Mr. Klein reviewed the letter, agreed with it and signed it as Appointing Authority. The suspension letter was admitted as Appellee's Exhibit 4 and is attached hereto as **Recommended Order Attachment A.**

8. Mr. Klein testified that the Appellant was treated better than others within the Cabinet.

9. On cross-examination, Mr. Klein admitted that although it is poor performance even if the home visits were completed but not documented, he felt that this was a less-serious violation. Nonetheless, he felt the three-day suspension was more than fair to the Appellant under the circumstances of this case.

10. The Appellee's second witness was **Jack Barnett**, who is employed with the Office of Human Resource Management for the Cabinet. Mr. Barnett drafted the suspension letter in this case.

11. Mr. Barnett testified that he reviewed the Request for Major Disciplinary Action, and also requested additional information. This information was introduced as Appellee's Exhibit 5, which consisted of a summary of the twenty cases. In addition, Appellee's Exhibit 6 was a list of the dates the cases were assigned to the Appellant. Mr. Barnett also reviewed the Appellant's evaluations and Performance Improvement Plans. He determined that the Appellant had a continuing problem with seeing that her documentation was completed.

12. Mr. Barnett testified that he reviewed the Appellant's policy violations with comparable cases. He found four very similar cases which had similar problems, but did not have as many cases as the Appellant.

13. On cross-examination, Mr. Barnett stated he did not contact any clients, and was not sure if there was a Performance Improvement Plan for 2012.

14. The Cabinet next called **Andrea Day**. Ms. Day is the Complaint Review Branch Manager with the Ombudsman's Office within the Cabinet for Health and Family Services. Ms. Day testified regarding a 2010 complaint, which was received on one of the Appellant's cases. This involved an overdue investigation. Based on their investigation, Ms. Day's branch found that this complaint was "justified resolved." She stated that this meant that the investigation was overdue, and was not in accordance with policy. During the course of their investigation, Ms. Blakemore completed the investigation and brought this matter into compliance. The investigation Ms. Day reviewed was not associated with any of the 20 cases Ms. Blakemore was suspended for.

15. The Cabinet called as its last witness **Tony Helm**. Mr. Helm is a Service Region Administrator Associate assigned to Hardin County. He has served in that capacity since 2011. He is the Appellant's second-line supervisor.

16. Mr. Helm prepared the Request for Major Disciplinary Action. (Appellee's Exhibit 1.) He stated the Appellant was scheduled to go on extended medical leave. At that time, her caseload was reassigned. When other workers began to work on her cases, Mr. Helm received complaints from supervisors that her cases were out of compliance. As a result, Mr. Helm performed a caseload audit, which resulted in the Request for Major Disciplinary Action. Based on his review, Mr. Helm found that the Appellant was out of compliance on 20 out of her 22 cases. Based on the lack of documentation in the files, Mr. Helm felt that children were being placed at risk by the manner in which Appellant was handling her caseload.

17. Through Mr. Helm's testimony, the Appellee introduced a series of Cabinet policies, which were introduced into the record as Appellee's Exhibits 8 through 18. These policies emphasize the importance of documentation and the need to meet with children and family members on a regular basis. The Appellant was required to prepare CQAs or Continuing Quality Assessment and Family Case Plans.

18. Mr. Helm introduced into evidence three performance improvement plans, which were issued to the Appellant in 2009 and 2010. All of these were efforts on the part of her supervisors to get her to improve her documentation, and to meet goals on completing case work. (Appellee's Exhibits 19, 20 and 21.)

19. Mr. Helm also introduced the Appellant's year-end evaluations for 2011 and 2012. (Appellee's Exhibits 22 and 23.)

20. The Appellant received three Performance Improvement Plans during 2011. They all concerned completing documentation and case work in a timely fashion. She received a year-end evaluation of "Good" for 2011.

21. The Appellant was issued a Performance Improvement Plan in 2012. She received an overall score of 189 on her evaluation, which was in the category of "Needs Improvement." The problems continued to be in the areas of documentation and completing case work in a timely fashion.

22. Mr. Helm testified that the case audit, which was conducted in 2012, when the Appellant's cases were reassigned because of her extended medical leave, revealed serious deficiencies in 20 cases out of her caseload of 22 cases. Mr. Helm testified that Client 1 involved an in-home case. The Appellant failed to document face-to-face monthly contacts with the child in June, July, August and September of 2012. In addition, the Appellant failed to file a Continuous Quality Assessment and Family Case Plan, which were due in September 2012.

23. With respect to Client 2, another in-home case, Mr. Helm testified that the Appellant missed monthly contacts from February through September 2012, and failed to timely complete a Continuous Quality Assessment and Family Case Plan, which were due in May 2012.

24. Client 3 involved an out-of-home care case in which the Appellant failed to complete a CQA and Family Case Plan, which were due in June 2012.

25. Client 4 was an out-of-home care case which involved a failure by the Appellant to document a monthly contact for September 2012, and failure to complete a CQA and Family Case Plan, which were due in May 2012.

26. Mr. Helm testified that Client 5 was an in-home case in which the Appellant missed contacts from March through September 2012. She also failed to complete CQAs, which were due in April 2012 and October 2012, as well as a Family Case Plan due in June 2012.

27. Client 6 was an in-home case in which the Appellant did not document monthly home visits in April through September 2012, and failed to complete a CQA and Family Case Plan which were due in May 2012.

28. Mr. Helm testified that Client 7 was an in-home case in which the Appellant failed to conduct required monthly visits in April through September 2012, and failed to complete a CQA which was due in June 2012, and a Family Case Plan which was due in July 2012.

29. Mr. Helm testified that Client 8 was an in-home case in which the Appellant failed to document monthly home visits in April through September 2012, and failed to complete a CQA and Family Case Plan, which were due in June 2012.

30. Client 9 involved an out-of-home case in which the Appellant failed to update an on-going CQA in April 2012 and a Family Case Plan in May 2012.

31. Mr. Helm testified that Client 10 was an in-home case in which the Appellant failed to document a monthly home visit in September 2012. She also failed to update an on-going CQA and Family Case Plan in October 2012.

32. Mr. Helm testified that Client 11 was an in-home case in which the Appellant failed to document a monthly home visit in September 2012, and failed to update an on-going CQA and Family Case Plan in October 2012.

33. Mr. Helm testified that Client 12 involved an out-of-home care case in which the Appellant failed to update an on-going CQA and complete an updated Family Case Plan in September 2012.

34. Mr. Helm testified that Client 13 was an in-home case in which the Appellant failed to document an on-going CQA, which was due in February 2012 and August 2012, and Family Case Plans which were due in March 2012 and September 2012.

35. Mr. Helm testified that Client 14 involved an in-home case in which the Appellant failed to document a home visit in September 2012, and failed to update an on-going CQA and Family Case Plan in October 2012.

36. Mr. Helm testified that Client 15 involved an in-home case in which the Appellant failed to document homes visits in July, August and September 2012.

37. Mr. Helm testified that Client 16 involved an out-of-home care case in which the Appellant failed to document a home visit in September 2012, and a CQA and Family Case Plan, which were due in August 2012.

38. Mr. Helm testified that Client 17 involved an in-home case assigned to the Appellant in which she failed to document home visits for August and September 2012.

39. Mr. Helm testified that Client 18 was an in-home case in which the Appellant failed to document home visits for April, May, June, July, August and September 2012, and failed to update an on-going CQA and Family Case Plan, which were due in May 2012.

40. Mr. Helm testified that Client 19 was an in-home case assigned to the Appellant in which she failed to document home visits from April 2012 through September 2012. She also failed to update an on-going CQA and Family Case Plan, which were due in August 2012.

41. Mr. Helm testified that Client 20 was an out-of-home care case in which the Appellant failed to update an on-going CQA and Family Case Plan, which were due in April 2012.

42. Mr. Helm testified that without this documentation, the children assigned to the Appellant's caseload were put at risk. He testified that in social work, if it is not documented, it did not happen. He testified that the documentation is necessary so that the Appellant's

supervisors or co-workers could pick up the file in her absence and be sure of the progress (or lack of progress) with respect to the client's case. In addition, he testified that the Court is looking for documentation when Social Workers go to Court and testify regarding progress with respect to the various clients.

43. Mr. Helm testified that the lack of documentation put the Cabinet at a disadvantage when new referrals were received on some of these families. In addition, the agency was put into a difficult position if it had to consider terminating parental rights without documentation.

44. Mr. Helm testified that he carefully reviewed the Appellant's cases in documenting these deficiencies. Introduced during his testimony was a management report, Appellee's Exhibit 24, and individual case documentation, Appellee's Exhibits 25.1 through 20. These exhibits were admitted into evidence under seal because they contain confidential client information. The documents introduced through Mr. Helm's testimony supported the deficiencies he testified about. In addition, Mr. Helm testified that he double-checked both the electronic files in TWIST and the hard files in the office, to ensure that he did not miss any documentation from the Appellant.

45. Mr. Helm testified that the requirements for a CQA changed in late 2013. Starting in that timeframe a shorter CQA was allowed. Reviewing the files, Mr. Helm testified that none of the documentation prepared by the Appellant during 2012 constituted a CQA as the Cabinet required during that timeframe.

46. Mr. Helm also testified that the court authorized Client 5s case to be closed during June of 2012. Nonetheless, Ms. Blakemore did not take the steps to close the file and needed to complete the documentation as it became due. Mr. Helm stated that the Appellant changed supervisors during calendar year 2012. He stated that Appellant's supervisors should have reviewed her cases with her on a monthly basis. From the documentation that he reviewed at the time of the hearing he could not tell if this was done because those documents were not present at the hearing for each case. He testified that the Appellant had an obligation to complete this documentation regardless of her supervisor's performance. Mr. Helm emphasized that the Appellant was a seasoned Clinician and should be able to handle a caseload. Regardless of deficiencies, she always had a supervisor to report to. Mr. Helm never received a grievance or complaint from Ms. Blakemore about a lack of supervision.

47. During Mr. Helm's testimony the parties stipulated that none of the documents introduced by the Appellee would show any case consultation by Appellant's supervisors. The Cabinet did not stipulate that there was no case consultation, but simply that the documents introduced into evidence would not demonstrate that these consultations took place. Following the conclusion of Mr. Helm's testimony the Appellee rested its case in chief.

48. The Appellant called as her first witness **Corinsa Smith-Williams**. Ms. Smith-Williams was previously a Social Service Worker for the Appellee assigned to Hardin County.

She was coworker of the Appellant. She testified that there was a period of four or five days in 2012 where they could not enter contacts into TWIST because the system was down.

49. During 2012, Smith-Williams testified that she and the Appellant went through a number of supervisors. She stated they started with Clem McStoots who stepped down a couple of months into 2012 allegedly because of bullying within the office. She stated thereafter Lisa Clark separated the team and they were also supervised by Brandi Bragg. She stated that two specialists came in while the team was split and in September 2012 Paula Mitchell became the supervisor. She felt that during 2012 there was a lot of confusion and frustration with little direction in the office. She testified that she was trained by supervisors who told her how to do the work. She stated they did not have a lot of time for Standard Operating Procedures.

50. Ms. Smith-Williams worked with the Cabinet from January of 2011 until April of 2014 when she resigned. She resigned following a meeting where she was confronted about possible disciplinary action. Prior to that time, she had received a written reprimand and a Performance Improvement Plan.

51. Ms. Smith-Williams testified that she believed minorities were treated differently within the Hardin County office. She stated that white employees were allowed to get away with discrepancies on their travel vouchers.

52. The Appellant, **Sharra Blakemore**, testified as her last witness. The Appellant is employed by the Cabinet as a Social Service Clinician I. She described herself as an ongoing worker in Hardin County. She has worked for the Cabinet for thirteen years and has been a Social Service Clinician I for nine or ten years.

53. In referring to the disciplinary action, the Appellant stated that she "did the work" and saw her clients. She stated that she had a good relationship with her clients. She stated that when she returned from her extended medical leave, no one told her there were any major problems with any of her cases.

54. Ms. Blakemore testified at length about the twenty clients in this case, remembering details about the families off-the-cuff. She testified that she loves her job. She stated she saw these families and that they were safe. She stated she has been in the home, she has visited with them outside the home and took great offense at the testimony that her actions were placing children at risk.

55. The Appellant testified that in 2012 she had a lot on her plate and fell behind on documentation. She stated that she was assigned a case other than the twenty she was accused of being deficient on. She believes there was disagreement between her and her supervisors in the way she handled the case and the way she testified in court. She testified that this case kept her busy for 2012. She also stated that she scheduled her surgery, which caused her extended medical leave, around actions in that case. The Appellant testified that the Judge asked her personal opinion on this case one day in court and she gave her opinion. She stated that her

supervisor disagreed with her opinion and told her. She believed she was treated unfairly because of the way she handled this case.

56. With respect to Client 5, the Appellant testified that she did not close the case because she did not have a supervisor at that time. During that period of time she had a specialist who did not have access to the case and did not remind her to close the case. She stated that supervisors are anxious to have cases closed because the numbers reflect on the supervisor. She stated that it is not the same with the specialists.

57. In general, Ms. Blakemore testified that she got into a pattern where she would do visits, but she would not put them in TWIST. She stated that at various times she would get messages from her supervisors to put contacts in. During the period in 2012 she was not getting these messages and did not document her visits. The Appellant emphasized that there were no new reports or referrals in her cases indicating that these families were not at risk.

58. The Appellant also felt she had been treated unfairly by the Cabinet. She specifically referred to the Cabinet not coming to her aid when she had been subpoenaed to testify in court when she was off on extended medical leave.

FINDINGS OF FACT

1. The Appellant, Sharra Blakemore, is employed as a Social Service Clinician I in Hardin County for the Cabinet for Health and Family Services. She has worked for the Cabinet for thirteen years and nine or ten years as a Social Service Clinician I. (Testimony of the Appellant.)

2. In 2012, the Appellant had a caseload of twenty-two ongoing cases. These involved families that had been referred to the Appellee for monitoring due to allegations of abuse or neglect. (Testimony of Tony Helm.)

3. The Appellant had obligations with respect to these cases. She was supposed to have face-to-face home visits with the children in these cases once a month for in-home cases and every three months for out-of-home care cases. In addition, Continuous Quality Assessments (CQA) were to be updated every six months and Family Case Plans were to be updated every six months. (Testimony of Tony Helm.)

4. In 2012, shortly before the Appellant was scheduled for extended medical leave, her cases were reassigned to other workers. Reports came in to Appellant's second-line supervisor, Tony Helm, the SRAA, that there were deficiencies in the Appellant's cases. As a result of these allegations, Mr. Helm conducted a full-case audit of the Appellant's cases. (Testimony of Tony Helm.)

5. Based on the full-case audit, Mr. Helm found deficiencies in twenty of the twenty-two cases. (Testimony of Tony Helm and Appellee's Exhibit 1.)

6. The Appellant was required to have face-to-face contact with the clients in these cases. The testimony established that she failed to document this contact in sixteen of the cases, those involving Clients 1, 2, 4, 5, 6, 7, 8, 10, 11, 13, 14, 15, 16, 17, 18, and 19. The Appellant failed to document monthly visits to Client 2's home for eight consecutive months. She failed to document monthly visits to Client 5's home for seven consecutive months. In the cases of Clients 6, 7, 8, 13, 18 and 19 she failed to document home visits for six consecutive months. (Testimony of Tony Helm and Appellee's Exhibits 1, 4 and 25.)

7. The Appellant emphasized throughout the hearing and during her testimony that she visited these clients on a monthly basis. She testified that she was overwhelmed with other duties and did not always document these cases. She testified that her clients were safe because she made the visits and was aware of what was going on in her cases. She did not dispute the lack of documentation of these visits. She blamed some of this failure on the lack of supervision during 2012. (Testimony of the Appellant.)

8. The Hearing Officer finds that documentation of home visits is a crucial part of the Cabinet's mission with respect to these families. While it is good that the Appellant made these home visits, it is equally important that these home visits be documented so that the Cabinet can track the progress of these clients and make appropriate decisions with respect to these families and keep children safe in these instances.

9. The Appellant was also required to document CQAs and Family Case Plans every six months. The Appellant failed to complete these documents in a timely fashion in eighteen of these twenty cases. The cases she failed to complete CQAs and Family Case Plans are Clients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 18, 19 and 20. In the case of Client 13 she missed two CQAs and two Family Case Plans. The Appellant did not dispute that she failed to complete these documents. Completing these documents was an important part of her duties as a Social Worker and this documentation is crucial to the Cabinet in carrying out its mission to these families and especially the children. (Testimony of Tony Helm, Appellant and Appellee's Exhibits 1, 4 and 25.)

10. Failure to complete this documentation in a timely fashion constituted unsatisfactory performance of duties by the Appellant and the Appellee was justified in taking disciplinary action as a result. Under the facts and circumstances of this case a three-day suspension was issued for just cause and was neither excessive nor erroneous. The evidence demonstrates that through training, Cabinet policy, employee evaluations and Performance Improvement Plans, the Appellant was on notice that the Appellee considered this documentation a crucial component of the Appellant's duties as a Social Service Clinician I.

11. While there was evidence that there were some problems with respect to the turnover of supervisors and specialists who assisted the Appellant during 2012, the Appellant's unsatisfactory performance was so widespread, twenty out of her twenty-two cases, that it cannot be blamed on some failure of her supervisors and disciplinary action was justified. The three-day suspension issued in this case appears to be a measured response to the Appellant's poor

performance. The Appellee appears genuinely interested in assisting the Appellant in correcting her ongoing failure to document her cases. Testimony demonstrated that the Appellant is passionate about her work for the Cabinet and truly cares about the children that are entrusted to her. Clearly the Appointing Authority is hopeful that this disciplinary action will get the Appellant's attention and demonstrate to her the importance of completing documentation in a timely fashion.

CONCLUSIONS OF LAW

1. As demonstrated by the Findings of Fact, the Cabinet demonstrated just cause for the three-day suspension of the Appellant and this penalty was neither excessive nor erroneous. The widespread failure of the Appellant to document in twenty out of her twenty-two cases warranted the three-day suspension in this case. KRS 18A.095(1) and (22).

2. The Appellant failed to establish that there was anything unfair about the disciplinary action in this case or that she had been singled out by her supervisors or the Appointing Authority. Although it is admirable that the Appellant visited these homes and children, the documentation is a necessary part of her duties and the Cabinet established that this is a standard that it holds all of its workers to.

RECOMMENDED ORDER

The Hearing Officer recommends to the Personnel Board that the appeal of **SHARRA BLAKEMORE V. CABINET FOR HEALTH AND FAMILY SERVICES, (APPEAL NO. 2013-041)** be **DISMISSED.**

NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13B.110(4), each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file exceptions to the Recommended Order with the Personnel Board. In addition, the Kentucky Personnel Board allows each party to file a response to any exceptions that are filed by the other party within five (5) days of the date on which the exceptions are filed with the Kentucky Personnel Board. 101 KAR 1:365, Section 8(1). Failure to file exceptions will result in preclusion of judicial review of those issues not specifically excepted to. On appeal a circuit court will consider only the issues a party raised in written exceptions. See *Rapier v. Philpot*, 130 S.W.3d 560 (Ky. 2004).

Any document filed with the Personnel Board shall be served on the opposing party.

The Personnel Board also provides that each party shall have fifteen (15) days from the date this Recommended Order is mailed within which to file a Request for Oral Argument with the Personnel Board. 101 KAR 1:365, Section 8(2).

Each party has thirty (30) days after the date the Personnel Board issues a Final Order in which to appeal to the Franklin Circuit Court pursuant to KRS 13B.140 and KRS 18A.100.

ISSUED at the direction of **Hearing Officer Mark A. Sipek** this 2nd day of December, 2014.

KENTUCKY PERSONNEL BOARD

Boyce A. Crouch for

MARK A. SIPEK
EXECUTIVE DIRECTOR

A copy hereof this day mailed to:

Hon. Carrie Cotton
Ms. Sharra Blakemore

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF HUMAN RESOURCE MANAGEMENT

Steven L. Beshear
Governor

275 East Main Street, 5C-D
Frankfort, KY 40621
502-564-7770
502-564-3129
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

December 20, 2012

Sharra D. Blakemore

Re: Three (3) Day Suspension

Dear Ms. Blakemore:

Based on the authority of KRS 18A.095 and 101 KAR 1:345, you are hereby notified that you are officially suspended from duty and pay for a period of three (3) working days. The effective dates of your suspension are December 26, 2012; December 27, 2012; and December 28, 2012.

In accordance with 101 KAR 1:345, Section 1, you are being suspended from your position as a Social Service Clinician I with the Department for Community Based Services, Salt River Trail Service Region for the following specific reasons:

Unsatisfactory Performance of Duties. As reported by Service Region Administrator Nelson Knight, you fail to complete the required Continuous Quality Assessments (CQAs) and Family Case Plans, and fail to conduct required monthly contacts with clients.

According to the Department for Community Based Services (DCBS), Child Protective Services (CPS), Standard of Practice (SOP) 2.12, Completing the Continuous Quality Assessment (CQA) and Making a Finding, once you are assigned an investigative case, you are required to complete the Family In Need of Services Assessment (FINSA) or investigation/assessment within thirty (30) working days. Once the case is assigned as an ongoing case, according to CPS SOP 3.2, Timeframes for All In-Home Services Cases and SOP 3.12, Ongoing Assessments (CQA), you are required to update the Continuous Quality Assessment (CQA) at least every six (6) months and at least within thirty (30) days prior to the Family Case Plan periodic review, or when any significant change occurs in a family, such as a change in the composition of the family; loss of job; a change in family income; or the loss of basic needs being met.

Further, according to CPS SOP 3.1, Engaging the Family and Opening the Case; SOP 3.2, Timeframes for All In-Home Services Cases; SOP 4.14, Timeframes for all OOHC [Out of Home Care] Cases, and SOP 4.18, Ongoing Case Planning, you are required to ensure that Family Case Plans are developed within fifteen (15) calendar days of case assignment. Following the initial Family Case Plan, and if the child(ren) is in an Out of Home Care (OOHC) placement, you are required to hold a Family Case Planning conference periodic review as appropriate or as needed, but at least one (1) within five (5)

Recommended Order
Attachment A

working days of the child(ren)'s temporary removal hearing and/or order of temporary custody or placement date of a voluntary commitment and within every six 6) months thereafter until permanency is achieved. Additionally, for all cases, you are required to complete a Family Case Plan within six (6) months from the Family Case Planning conference date of the previous Family Case Plan, or if there are significant changes in the family, the Family Case Plan may be revised prior to the six (6) month periodic review.

According to CPS SOP 3.2, Timeframes for All In-Home Services Cases, you are required to visit your client(s) at least monthly (every thirty (30) calendar days), making face to face contact with the family and child in the client's home.

Further, according to CPS SOP 4.24, SSW's [Social Service Worker] Ongoing Contact with the Birth Family and Child (Including the Medically Fragile Child), if the child(ren) is placed in out of home care (OOHC), you are required to conduct a face to face visit with the child(ren) in their placement at least monthly (every thirty (30) calendar days) in order to assess progress toward Family Case Plan goals and objectives and to assess adjustment to OOHC placement. If the child(ren) is in a private child caring (PCC) facility or in private child placing (PCP) foster care, you are required to conduct private face to face contact in the child's placement setting at least quarterly. If a child is deemed a Medically Fragile Child, you are required to conduct face to face visits with the child a minimum of two (2) times per calendar month, with at least one (1) visit occurring in the placement setting, which includes a DCBS resource home, a PCP foster home, or a supports for community living (SCL) program. Additionally, you are required to have an annual private face to face contact in the child's placement setting if the child is placed out of state and monthly phone contact with the child or the child's placement if the child is placed out of state.

However, according to The Workers Information System (TWIST) TWS-M004 report dated October 5, 2012, you have failed to ensure client CQA's and Family Case Plans remain up-to-date, and/or have failed to conduct the required monthly face-to-face contacts (in-home visits) with families and children for twenty cases on your caseload, as follows:

- Client *1's CPS ongoing in-home case was assigned to you on or about May 7, 2012. This case involved a child whose meconium (the earliest stool from a newborn composed of materials ingested during the time the infant spends in the uterus) tested positive for methadone and metabolite, opiates, and marijuana. You conducted the last ongoing in-home visit to Client *1's home on May 11, 2012. You failed to conduct the required monthly home visits in Client *1's home in June 2012, July 2012, August 2012, and September 2012, for a total of four (4) months without an in-home visit to Client *1's home.

  Client *1's most recent updated CQA for the ongoing case is dated March 25, 2012. You have failed to complete the updated ongoing CQA every six (6) months, which was due on or before September 24, 2012.

  Client *1's most recent updated Family Case Plan for the ongoing case is dated March 25, 2012. You have failed to complete the updated Family Case Plan every six (6) months, which was due on or before September 24, 2012.

  Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *1 is not living in an environment that is an imminent risk of death or harm and that Client *1's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *1 is/is not making to resolve the

issue of concern that brought Client *1 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *1 may suffer from repeat maltreatment.

- You were assigned Client *2's CPS ongoing in-house case on or about October 19, 2011. This case involved a perpetrator who was arrested for DUI while the victim was in the backseat of the vehicle. You failed to conduct the required monthly visits in Client *2's home since January 5, 2012. Visits should have been done in February 2012, March 2012, April 2012, May 2012, June 2012, July 2012, August 2012, and September 2012, for a total of eight (8) months without an in-home visit to Client *2's home.

  Client *2's most recent updated CQA for the ongoing case is dated November 14, 2011. You have failed to complete the updated ongoing CQA every six (6) months, which was due on or before May 13, 2012.

  Client *2's most recent updated Family Case Plan for the ongoing case is dated November 29, 2011. You have failed to complete the updated Family Case Plan every six (6) months, which was due on or before May 28, 2012.

  Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *2 is not living in an environment that is an imminent risk of death or harm and that Client *2's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *2 is/is not making to resolve the issue of concern that brought Client *2 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *2 may suffer from repeat maltreatment.

- You were assigned Client *3's CPS ongoing OOHC case on or about January 24, 2012. This case involved a child who is suicidal and alleged that her mother has physically and emotionally abused her for her entire life. The most recent updated CQA is dated December 11, 2011. You failed to complete the updated ongoing CQA every six (6) months, which was due on or before June 10, 2012.

  Further, you failed to update the required Family Case Plan on Client *3's case since December 22, 2011. An updated Family Case Plan was due on or before June 21, 2012.

  Without updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *3 is not living in an environment that is an imminent risk of death or harm and that Client *3's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *3 is/is not making to resolve the issue of concern that brought Client *3 to the attention of DCBS. The past due CQA and Case Plan increase the chances that Client *3 may suffer from repeat maltreatment.

- Client *4's CPS ongoing OOHC case was assigned to you on or about November 7, 2011. This case involves allegations of a father putting a sheet over his 11 year old child's face and makes her get naked. You conducted the last visit in Client *4's home on August 9, 2012. You have failed to conduct the required monthly home visits in Client *4's home in September 2012.

Client *4's most recent updated ongoing CQA is dated November 28, 2011. You failed to complete the updated ongoing CQA every six (6) months, which was due on or before May 27, 2012.

Further, you failed to update the required Family Case Plan on Client *4's case since November 29, 2011. An updated Family Case Plan was due on or before May 28, 2012.

Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *4 is not living in an environment that is an imminent risk of death or harm and that Client *4's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *4 is/is not making to resolve the issue of concern that brought Client *4 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *4 may suffer from repeat maltreatment.

- You were assigned Client *5's CPS ongoing in-home case on or about October 14, 2011. This case involved allegations that the parents are neglecting the children, including failure to provide adequate clothing and food, because of drug abuse issues. You conducted the last visit in Client *5's home on February 9, 2012. You have failed to conduct the required monthly home visits in Client *5's home in March 2012, April 2012, May 2012, June 2012, July, 2012, August 2012, and September 2012, for a total of seven (7) months without an in-home visit with Client *5.

  Client *5's most recent updated CQA is dated October 14, 2011. Therefore, you failed to complete the updated ongoing CQA every six (6) months, which was due on or before April 13, 2012 and October 12, 2012.

  Further, you failed to update the required Family Case Plan on Client *5's case since December 2, 2011. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before June 1, 2012.

  Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *5 is not living in an environment that is an imminent risk of death or harm and that Client *5's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *5 is/is not making to resolve the issue of concern that brought Client *5 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *5 may suffer from repeat maltreatment.

- You were assigned Client *6's CPS ongoing in-house case on or about March 6, 2012. This case involved allegations of the mother abandoning her 7 month old child in a hotel room, while she and her 2 year old child were found in a different hotel's fountain (both nude) and she was holding the 2 year old in the water. You conducted the last visit in Client *6's home on March 15, 2012. You have failed to conduct the required monthly home visits in Client *6's home in April 2012, May 2012, June, 2012 July 2012, August 2012, and September 2012, for a total of six (6) months without an in-home visit to Client *6's home.

Client *6's most recent updated ongoing CQA is dated November 15, 2011. Therefore, you failed to complete the updated ongoing CQA every six (6) months, which was due on or before May 7, 2012.

Further, you have failed to update the required Family Case Plans on Client *6's case since November 8, 2011. An updated Family Case Plan was due on or before May 7, 2012.

Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *6 is not living in an environment that is an imminent risk of death or harm and that Client *6's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *6 is/is not making to resolve the issue of concern that brought Client *6 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *6 may suffer from repeat maltreatment.

- You were assigned Client *7's CPS ongoing in-home case on or about January 24, 2012. This case involved allegations of drug and alcohol abuse by the mother and allowing the child to drink alcohol. You conducted the last visit in Client *7's home on March 14, 2012. You have failed to conduct the required monthly visits in Client *7's home in April 2012, May 2012, June 2012, July 2012, August 2012, and September 2012, for a total of six (6) months without an in-home visit to Client *7's home.

  Client *7's most recent updated CQA is dated December 22, 2011. You have failed to complete the required updated ongoing CQA every six (6) months, which was due on or before June 21, 2012.

  Further, you failed to update the required Family Case Plan on Client *7's case since January 4, 2012. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before July 3, 2012.

  Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *7 is not living in an environment that is an imminent risk of death or harm and that Client *7's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *7 is/is not making to resolve the issue of concern that brought Client *7 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *7 may suffer from repeat maltreatment.

- Client *8's CPS ongoing in-home case was assigned to you as an on-going case on or about November 8, 2011. This case involved allegations of physical abuse of the children by the father. You have failed to conduct any of the required monthly home visits in Client *8's home since March 5, 2012. Therefore, you failed to visit Client *8's home in April 2012, May 2012, June 2012, July 2012, August 2012, and September 2012, for a total of six (6) months without an in-home visit to Client *8's home.

  Client *8's most recent updated ongoing CQA is dated December 12, 2011. You have failed to complete the updated ongoing CQA every six (6) months, which was due on or before June 11, 2012.

Further, you failed to update the required Family Case Plan on Client *8's case since December 14, 2011. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before June 13, 2012.

Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *8 is not living in an environment that is an imminent risk of death or harm and that Client *8's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *8 is/is not making to resolve the issue of concern that brought Client *8 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *8 may suffer from repeat maltreatment.

- You were assigned Client *9's CPS ongoing OOHC case on or about November 7, 2011. This case involved allegations that the legal custodian was failing to pick the child up at school on a daily basis due to being intoxicated. Client *9's most recent updated ongoing CQA is dated October 31, 2011. You have failed to complete the updated ongoing CQA every six (6) months, which was due on or before April 30, 2012.

  You failed to update the required Family Case Plan on Client *9's case since November 29, 2011. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before May 28, 2012.

  Without updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *9 is not living in an environment that is an imminent risk of death or harm and that Client *9's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *9 is/is not making to resolve the issue of concern that brought Client *9 to the attention of DCBS. The past due CQA and Case Plan increase the chances that Client *9 may suffer from repeat maltreatment.

- Client *10's CPS ongoing in-home case was assigned to you on or about May 15, 2012. This case involved a case where one biological parent is homeless and the other is believed to have mental health issues, and the legal custodian reports that she can no longer take care of the children. You have failed to conduct any of the required monthly home visits in Client *10's home since August 10, 2012. Therefore, you failed to visit Client *10's home in September 2012.

  Client *10's most recent updated ongoing CQA is dated April 13, 2012. Therefore, you failed to complete the updated ongoing CQA every six (6) months, which was due on or before October 12, 2012.

  You failed to update the required Family Case Plan on Client *10's case since April 13, 2012. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before October 12, 2012.

  Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *10 is not living in an environment that is an imminent risk of death or harm and that Client *10's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *10 is/is not making to resolve the issue of concern that brought Client *10 to the attention of DCBS. The past due

CQAs/Case Plans and missed home visits increase the chances that Client *10 may suffer from repeat maltreatment.

- Client *11's CPS ongoing in-home case was assigned to you on or about October 20, 2011. This case involves allegations of physical abuse by the father. You have failed to conduct any of the required monthly home visits in Client *11's home since August 7, 2012. Therefore, you failed to visit Client *11's home in September 2012.

  Client *11's most recent updated ongoing CQA is dated April 2, 2012. Therefore, you failed to complete the updated ongoing CQA every six (6) months, which was due on or before October 1, 2012.

  You failed to update the required Family Case Plan on Client *11's case since April 3, 2012. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before October 2, 2012.

  Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *11 is not living in an environment that is an imminent risk of death or harm and that Client *11's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *11 is/is not making to resolve the issue of concern that brought Client *11 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *11 may suffer from repeat maltreatment.

- Client *12's CPS ongoing OOHC case was assigned to you on or about April 17, 2012. This case involved allegations of domestic violence by the father towards the mother. Client *12's most recent updated ongoing CQA is dated April 6, 2012. Therefore, you failed to complete the updated ongoing CQA every six (6) months, which was due on or before September 19, 2012.

  You failed to update the required Family Case Plan on Client *12's case since March 20, 2012. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before September 19, 2012.

  Without updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *12 is not living in an environment that is an imminent risk of death or harm and that Client *12's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *12 is/is not making to resolve the issue of concern that brought Client *12 to the attention of DCBS. The past due CQA and Case Plan increase the chances that Client *12 may suffer from repeat maltreatment.

- Client *13's CPS ongoing in-home case was assigned to you on or about October 20, 2011. This case involved allegation that the mother fails to obtain necessary services for the children. You have failed to conduct any of the required monthly home visits in Client *13's home since March 5, 2012. Therefore, you failed to visit Client *13's home in April 2012, May 2012, June 2012, July 2012, August 2012, and September 2012, for a total of six (6) months without an in-home visit to Client *13's home.

Client *13's most recent updated ongoing CQA is dated September 1, 2011. Therefore, you failed to complete the updated ongoing CQA's every six (6) months, which were due on or before February 19, 2012 and August 21, 2012

You failed to update the required Family Case Plan on Client *13's case since September 13, 2011. You failed to complete updated Family Case Plans every six (6) months, which were due on or before March 12, 2012, and September 11, 2012.

Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *13 is not living in an environment that is an imminent risk of death or harm and that Client *13's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *13 is/is not making to resolve the issue of concern that brought Client *13 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *13 may suffer from repeat maltreatment.

- Client *14's CPS ongoing in-home case was assigned to you on or about October 20, 2011. This case involved allegations of a child being neglected by the mother who had a substance abuse problem. You have failed to conduct any of the required monthly home visits in Client *14's home since August 10, 2012. Therefore, you failed to visit Client *14's home in September 2012.

  Client *14's most recent updated ongoing CQA is dated April 3, 2012. Therefore, you failed to complete the updated ongoing CQA every six (6) months, which was due on or before October 2, 2012.

  You failed to update the required Family Case Plan on Client *14's case since April 3, 2012. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before October 2, 2012.

  Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *14 is not living in an environment that is an imminent risk of death or harm and that Client *14's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *14 is/is not making to resolve the issue of concern that brought Client *14 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *14 may suffer from repeat maltreatment.

- Client *15's CPS ongoing in-home case was assigned to you on or about June 13, 2012. In this case, the Cabinet was ordered by the court to assign a worker and report regarding health of the children. You have failed to conduct any of the required monthly home visits in Client *15's home since June 6, 2012. Therefore, you failed to visit Client *15's home in July 2012, August 2012, and September 2012, for a total of three (3) months without an in-home visit to Client *15's home.

  Without documented monthly visits, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *15 is not living in an environment that is an imminent risk of death or harm and that Client *15's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *15 is/is not making to resolve the issue of concern that brought

Client *15 to the attention of DCBS. The missed home visits increase the chances that Client *15 may suffer from repeat maltreatment.

- Client *16's CPS ongoing OOHC case was assigned to you on or about October 20, 2011. This case involved a mother who was arrested and that there was allegedly a meth lab in the home. You have failed to conduct any of the required monthly home visits in Client *16's home since August 24, 2012. Therefore, you failed to visit Client *16's home in September 2012.

  Client *16's most recent updated ongoing CQA is dated April 10, 2012. Therefore, you failed to complete the updated ongoing CQA every six (6) months, which was due on or before August 12, 2012.

  You failed to update the required Family Case Plan on Client *16's case since February 13, 2012. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before August 12, 2012.

  Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *16 is not living in an environment that is an imminent risk of death or harm and that Client *16's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *16 is/is not making to resolve the issue of concern that brought Client *16 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *16 may suffer from repeat maltreatment.

- Client *17's CPS ongoing in-home case was assigned to you on or about May 10, 2012. This case involved allegations of neglect by the natural father who allegedly was unaware of repeated occurrences where his child was repeatedly leaving the home and crossing a two lane street and walking to a nearby school playground. Also, the child had to be returned home multiple times by several different individuals. You have failed to conduct any of the required monthly home visits in Client *17's home since July 17, 2012. Therefore, you failed to visit Client *17's home in August 2012 and September 2012, for a total of two (2) months without an in-home visit to Client *17's home.

  Without documented monthly visits, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *17 is not living in an environment that is an imminent risk of death or harm and that Client *17's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *17 is/is not making to resolve the issue of concern that brought Client *17 to the attention of DCBS. The missed home visits increase the chances that Client *17 may suffer from repeat maltreatment.

- Client *18's CPS ongoing in-home case was assigned to you on or about February 7, 2012. This case was court ordered due to the children's refusal to attend school on a regular basis. You have failed to conduct any of the required monthly home visits in Client *18's home since March 1, 2012. Therefore, you failed to visit Client *18's home in April 2012, May 2012, June 2012, July 2012, August 2012, and September 2012, for a total of six (6) months without an in-home visit to Client *18's home.

Client *18's most recent updated ongoing CQA is dated November 28, 2011. Therefore, you failed to complete the updated ongoing CQA every six (6) months, which was due on or before May 27, 2012.

You failed to update the required Family Case Plan on Client *18's case since December 1, 2011. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before May 31, 2012.

Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *18 is not living in an environment that is an imminent risk of death or harm and that Client *18's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *18 is/is not making to resolve the issue of concern that brought Client *18 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *18 may suffer from repeat maltreatment.

- Client *19's CPS ongoing in-home case was assigned to you on or about October 20, 2011. This case involved a three year old child who was found in a vehicle containing a meth lab in a park. You have failed to conduct any of the required monthly home visits in Client *19's home since March 28, 2012. Therefore, you failed to visit Client *19's home in April 2012, May 2012, June 2012, July 2012, August 2012, and September 2012, for a total of six (6) months without an in-home visit to Client *19's home.

  Client *19's most recent updated ongoing CQA is dated February 10, 2012. Therefore, you failed to complete the updated ongoing CQA every six (6) months, which was due on or before August 9, 2012.

  You failed to update the required Family Case Plan on Client *19's case since February 10, 2012. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before August 9, 2012.

  Without documented monthly visits, updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *19 is not living in an environment that is an imminent risk of death or harm and that Client *19's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *19 is/is not making to resolve the issue of concern that brought Client *19 to the attention of DCBS. The past due CQAs/Case Plans and missed home visits increase the chances that Client *19 may suffer from repeat maltreatment.

- Client *20's CPS ongoing OOHC case was assigned to you on or about October 21, 2011. This case involves a natural father who told his child to pack her things and leave, and allows her to stay wherever she ends up. Client *20's most recent updated ongoing CQA is dated October 21, 2011. Therefore, you failed to complete the updated ongoing CQA every six (6) months, which was due on or before April 20, 2012.

  You failed to update the required Family Case Plan on Client *20's case since October 21, 2011. You failed to complete an updated Family Case Plan every six (6) months, which was due on or before April 20, 2012.

Without updated CQAs and updated case plans, you cannot ensure through visual observation, verbal discussions, and review of written documentation that Client *20 is not living in an environment that is an imminent risk of death or harm and that Client *20's basic needs are being met by the parents/custodians. You are not able to continually assess the progress or lack of progress Client *20 is/is not making to resolve the issue of concern that brought Client *20 to the attention of DCBS. The past due CQA and Case Plan increase the chances that Client *20 may suffer from repeat maltreatment.

In addition, as outlined in your 2012 annual performance expectations, you are required to be 90% compliant in completing CQAs timely. As shown below, you have failed to meet this expectation during the second interim evaluation period from May 2012 through August 2012:

Month in 2012 Evaluation Year	Percentage of CQA Timely
May	0.00%
June	57.89%
July	47.37%
August	45.00%
Interim Total	37.57%

As outlined in your 2012 annual performance expectations, you are required to be 90% compliant in completing Case Plans timely. As shown below, you have failed to meet this expectation during the second interim evaluation period from May 2012 through August 2012:

Month in 2012 Evaluation Year	Percentage of CQA Timely
May	100.00%
June	61.11%
July	52.63%
August	40.00%
Interim Total	63.44%

As outlined in your 2012 annual performance expectations, you are required to be 90% compliant in completing all requested/agency contacts timely. As shown below, you have failed to meet this expectation during the second interim evaluation period from May 2012 through August 2012:

Month in 2012 Evaluation Year	Percentage of All Requested/Agency Contacts Timely
May	0.00%
June	42.11%
July	47.37%
August	60.00%
Interim Total	37.37%

As outlined in your 2012 annual performance expectations, you are required to be 90% compliant in completing visits to children in OOHC in DCBS homes timely. As shown below, you have failed to meet this expectation during the second interim evaluation period from May 2012 through August 2012:

Month in 2012 Evaluation Year	Percentage of Visits to Children in OOHC in DCBS Homes Timely
May	40.00%
June	42.86%
July	100.00%
August	100.00%
Interim Total	70.72%

Previous efforts to improve your unsatisfactory performance of duties include:

- On October 12, 2009, you were issued a Performance Improvement Plan (PIP) which specifically stated, "Ms. Blakemore has to improve in timely completion of referrals" and "Ms. Blakemore has to decrease the number of past due cases on her case load." The PIP was effective until December 31, 2009.

- On January 12, 2010, you were issued a PIP which cited your need to complete current investigation timely and to reduce the number of past due investigations. The PIP was effective until April 25, 2010.

- On May 27, 2010, you were issued a PIP which again cited your need to reduce past due investigations. In addition, the PIP stated, "Sharra will make face to face contact with all children in OOHC [Out of Home Care] on her caseload every month and enter the contact in TWIST." The PIP was effective until July 31, 2010.

- On January 20, 2011, you were issued a PIP which specifically stated, "75% of all assessments/investigations will be completed timely; currently at 43.19%" and "80% of all cases worker visits to children in OOHC in DCBS homes will be completed timely; currently at 16.67%" The PIP was effective until April 20, 2011.

- On May 27, 2010, you were issued a PIP which again cited your need to complete your assessments/investigations timely. The PIP was effective until August 30, 2011.

- On August 28 2011, you were issued a PIP which specifically stated, "95% of all CPS [Child Protective Services] investigations/FINSAs [Families in Need of Service Assessment] initiated timely; currently at 73.29%" and "75% of all assessments/investigations will be completed timely; currently at 49.55%" The PIP was effective until December 31, 2011.

- Your poor work performance was addressed in your May 30, 2012 and September 27, 2012 interim reviews. Due to your continual unsatisfactory performance, you were again placed on a PIP on September 27, 2012

- Additionally, since the start of 2012, you have received oversight including individual and team meetings to review and discuss reports and cases and one on one coaching, mentoring, and supervision to address specific case concerns from former Family Services Office

Supervisor (FSOS) Bandi Bragg, FSOS Kimberly Mudd, Social Service Specialist (SSS) Kelly Dorman, SSS Melissa Farmer, and your present FSOS Paula Mitchell.

Despite efforts to improve your poor work performance, you have failed to conduct the required visits to clients on your caseload; ensure that updated CQA's were completed every six (6) months for all on-going cases; and failed to ensure that updated Family Case Plans were completed, entered, and submitted to clients on your caseload every six (6) months for all ongoing cases. As a Social Service Clinician I, you knew or should have known that your inaction toward the clients you serve violated DCBS' Standard of Practice (SOP) 2.12, Completing the Continuous Quality Assessment (CQA) and Making a Finding; SOP 3.1, Engaging the Family and Opening the Case; SOP 3.2, Timeframes for All In-Home Services Cases; SOP 3.12, Ongoing Assessments (CQA); SOP 4.14, Timeframes for all OOHC Cases; SOP 4.18, Ongoing Case Planning, SOP 4.24, SSW's [Social Service Worker's] Ongoing Contact with the Birth Family and Child (Including the Medically Fragile Child); SOP 1A.1, Ethical Practice; and the Cabinet for Health and Family Services' Personnel Procedure 2.1, Employee Conduct. Further, your actions constitute unsatisfactory performance of duties for which you may be disciplined pursuant to 101 KAR 1:345, Section 1.

Further incidents in violation of policy may lead to further and more severe disciplinary action, up to and including dismissal.

To keep confidential the identities of Clients *1 - Client *20, as required by law, the names of the clients referenced are transmitted by the attached list marked "CONFIDENTIAL" which is not to be disclosed without proper authorization. Further, you are not authorized to disclose the following clients' names to anyone, including any attorney who may be representing you as counsel.

For your information, the Kentucky Employee Assistance Program (KEAP) is a voluntary and confidential assessment and referral service for state employees. This service may help you with any personal problems that may be affecting your job performance. KEAP can be reached at 1-800-445-5327 or (502) 564-5788.

As you are an employee with status, you may appeal this action to the Personnel Board within sixty (60) days after receipt of this notice, excluding the day of receipt. To appeal, you must complete the attached form and direct it to the address indicated on the form. Copies of KRS 18A.095 and 101 KAR 1:365 concerning appeal and hearing procedures are enclosed.

Sincerely,

Howard J. Klein
Appointing Authority

HJK:jcb

Attachments

cc: Secretary Tim Longmeyer, Personnel Cabinet
Executive Director Mark Sipek, Personnel Board
Commissioner Teresa James, Department for Community Based Services
Service Region Administrator Nelson Knight, Salt River Trail Service Region
Cabinet Personnel File