WEST VIRGINIA PUBLIC EMPLOYEES GRIEVANCE BOARD

JORDAN WATSON,

Grievant,

v. **Docket No. 2024-0420-DHHR**

DEPARTMENT OF HEALTH AND HUMAN RESOURCES/ WILLIAM R. SHARPE, JR. HOSPITAL,

Respondent.

DECISION

Grievant, Jordan Watson, is employed by Respondent, the Department of Health Facilities (DHF),[1] at Sharpe Hospital (Sharpe) as a therapist. On November 7, 2023, Grievant received a five-day unpaid disciplinary suspension for neglect when a patient went unescorted to his unit. On November 16, 2023, Grievant filed a grievance, stating:

> [U]njustified suspension. Respondent[']s actions were capricious and arbitrary in nature. I have been subjected to a hostile work environment.

As relief, Grievant requests:

> Removal of disciplinary action from person[n]el file. [F]ull backpay with interest. Cessation of hostile work environment.

Grievant grieved directly to level three of the grievance process as permitted for unpaid suspensions by West Virginia Code § 6C-2-4(a)(4). A level three hearing was held by videoconference before the undersigned on November 19, 2024. Grievant appeared and was self-represented. Respondent was represented by Gail Lipscomb, Assistant

[1]As of January 1, 2024, the agency formerly known as the Department of Health and Human Resources is now three separate agencies -- the Department of Health Facilities, the Department of Health, and the Department of Human Services. For purposes of this grievance, the Department of Health and Human Resources, or DHHR, shall mean the Department of Health Facilities.

Attorney General. This matter matured for decision on December 30, 2024. Each party submitted proposed findings of fact and conclusions of law.[2]

Synopsis

Grievant is employed at Sharpe as a therapist. Grievant rarely handed off patients after therapy but was never disciplined until Sharpe emailed employees a one-time change in patient hand-off location. Months later, when a patient left therapy unescorted, Grievant received a five-day unpaid suspension for patient neglect. Respondent now claims this incident also violated its written hand-off policy and email directive. Respondent failed to prove the existence of a hand-off directive or a written hand-off policy. While not written policy, Respondent showed that leaving a patient unattended is neglect. Yet, Respondent did not prove that Grievant was mandated to verbalize a hand-off or that the enacted discipline was justified. Grievant failed to prove a hostile work environment. Accordingly, the grievance is GRANTED, in part, and DENIED, in part.

The following Findings of Fact are based upon a complete and thorough review of the record created in this grievance:

Findings of Fact

1. Grievant is employed at Sharpe by Respondent DHF as a Substance Abuse Therapist (SAT) I.

2. Sharpe is a State-owned psychiatric hospital operated by DHF and houses patients suffering from mental illness, some of whom are being held for violent crimes.

3. Grievant began his current stint at Sharpe in December 2022 but had previously been employed at Sharpe for five years.

[2]Grievant's request for mitigation will not be further addressed since it was not properly grieved.

4. On August 25, 2023, Sharpe's Clinical Services Director, Charity Heding, emailed Grievant and many other employees as follows:

> Today there will be additional activities in the MP [Multi-Purpose] Room occurring. Due to this the bus stop area (where you pick up patient[s] from and return them to) for group will be by the hair salon area near C1 as we have done before.

5. In practice, a patient "hand-off" entails transferring physical custody of the patient to another employee, often an ambassador or hall-monitor, or bringing the patient directly to a predetermined hand-off location such as the multi-purpose room.

6. On October 11, 2023, after a therapy session with Grievant, Patient CC[3] returned to his residential unit unescorted. Grievant and Patient CC left the therapy room together. As a hall-monitor approached Patient CC, Grievant stopped to talk to another employee. Grievant never verbalized a hand-off of Patient CC to the hall-monitor or anyone else. As Grievant was preoccupied in conversation, Patient CC passed the hall-monitor without being intercepted or without Grievant noticing and continued to the stairwell up to his residential unit.

7. A complaint was lodged by an employee who encountered Patient CC entering the stairwell alone, whereupon Sharpe and Legal Aid of West Virginia conducted separate investigations. Each investigation substantiated abuse and neglect.

8. On October 31, 2023, Sharpe held a predetermination meeting with Grievant, his representative, and Sharpe HR Director Cecil Pritt. Grievant was given the opportunity to explain his actions and was informed of the disciplinary actions being considered.

[3]Initials are used to protect a patient's identity.

9. A disciplinary letter is the charging document that both specifies the discipline enacted and the reasons for the discipline.

10. On November 7, 2023, Sharpe issued Grievant a letter for a five-day unpaid disciplinary suspension, stating in part:

> This disciplinary suspension is the result of your misconduct, specifically, it has been determined that based on the findings of the substantiated investigation, the evidence supports the allegation of neglect.
>
> - On October 11, 2023, you conducted MICA services with a patient in the MICA classroom, near the Therapy Mall Hallway. Upon completion of the service, the patient was observed walking away unescorted back to his unit.
>
> The investigation has concluded and determined that the allegation of neglect was substantiated by Legal Aid and Facility investigator.

11. The letter goes on to cite and discuss policies on employee conduct and patient neglect, including DHHR Policy 2108, Sharpe Policy 34.305, and Sharpe Policy 45.034. None of these policies mentions patient hand-offs. Nor does the disciplinary letter cite Grievant for violating any hand-off directive or policy.

12. While the letter does not allege that Grievant failed to follow a directive, it cites Sharpe Policy 34.305 as including the expectation that employees "follow directives of his/her supervisor" and DHHR Policy 2108 as including the expectation that employees "follow directives of their management personnel."

13. As for neglect, the disciplinary letter alleges that Grievant violated Sharpe Policy 45.034, and accurately cites the policy (but not West Virginia Code) to define "neglect" as:

> Actions of omission or commission within the meaning of W.Va. Code § 9-6-1(3)[4], that violate 42 C.F.R. § 482.13, or that constitute a breach of the applicable standard of care, including the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.
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> a. W.V. Code. §9-6-1(3)[5] – The unreasonable failure by a hospital employee or contract staff to provide the care necessary to maintain the safety or health of a patient or that results in the self-neglect of a patient, including the use of undue influence by a hospital employee or contract staff the causes or contributes to self-neglect;
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> b. 42 C.F.R. § 482.13 – The failure to provide goods and services that are necessary to avoid a patient's physical harm, mental anguish, or mental illness.
>
> c. Breach of the standard of care for the treatment of a patient.

14. The actual code language from West Virginia Code § 9-6-1(4) is slightly different, stating, "'Neglect' means the unreasonable failure by a caregiver to provide the care necessary to maintain the safety or health of a vulnerable adult or self-neglect by a vulnerable adult, including the use of undue influence by a caregiver to cause self-neglect."

15. The letter further hints at the meaning of "neglect" in accurately citing DHHR Policy 2108 as setting forth an expectation that employees "exercise standard client management techniques" and "follow appropriate safety precautions."

16. In practice, it appears that Sharpe has unwritten protocol to assure patient safety by ensuring patients are always in an employee's custody when not in their room.

[4]Yet, West Virginia Code § 9-6-1(3) only defines "abuse." West Virginia Code § 9-6-1(4) defines "neglect."

[5]This seems to be an old definition of "neglect" which has been updated in West Virginia Code § 9-6-1(4).

17. The letter of suspension does not set forth any alleged action or inaction on Grievant's part that led to his discipline but only passively hints at his inaction in stating that "[after the therapy session with Grievant] the patient was observed walking away unescorted back to his unit."

18. While the disciplinary letter does not directly accuse Grievant of failing to hand-off Patient CC or of violating an apparent obligation to do so, it does make the following allusion to lack of hand-off in quoting Grievant's explanation during the predetermination conference:

> On October 31, 2023, you (along with your representative Krista Adkins) participated in a predetermination conference with Human Resources Director, Cecil Pritt. The purpose of that conference was to inform you that disciplinary action was being considered and to give you an opportunity to explain yourself and the circumstances involved. During that conference, you provided the following responses for our consideration.
>
> You indicated 'I did watch it, I'll explain a little bit…. patient turns right, we turn left. We let him turn right we obviously seen him turn right…..he turned right behind an ambassador with a group of patients walking down the hall. […] The gym is considered the bus stop. The patients are supposed to be in this bus stop before and after groups, but the fact is, they never go into this bus stop after groups. Imagine….me having ten patients in my group, me opening up my door by myself, with ten patients, letting one patient out, the first one go out, and then waiting on the other nine, across the library into the café……now tell me is there any possible way that I could watch all ten of those patients, walk through that hallway into the café, and be accountable for all of them, without the ambassador's, or transport, or the hall monitors being in their designated positions, verifying the patients are going the correct way. There's no way, it's impossible way. I just assumed they're doing their jobs correctly, like it's crazy to me that I'm held responsible for making a mistake, by thinking someone else is doing their job. The people that completely disregarded their job...I mean there was no hall monitors right, because if there was, he walked by two. I was the first line of

> defense, I would think if anybody would be more accountable than the others, it would have be the last two lines of defense as I just made a simple mistake.' You went on to state that you had problems with patients going into the gym because they have never done it before, and it didn't make sense to them. You continued 'as far as I'm aware was never really directed on exactly what we're to do after our groups. I have never heard any clear directive as to what we do after group, because again, it's not clear, it's not concise.' You continued 'I wish they would watch more cameras instead of just the one of us walking down the hall….I think it's a complete false reading of the whole situation'. You continued 'that if me and Marie were APS'd over this, how is somebody that completely disregarded their position or policy such as a hall monitor, that doesn't even do their job, so right, we made a simple mistake……while doing our jobs, these people just completely disregarded their duties altogether and don't do the job. How are we held accountable and them not?' You continued 'it's almost bothersome how I transport now going forward'. You continued 'like I said, if everyone would have done their specific jobs, this wouldn't be an issue, right, if everybody would have done their job that day, if everybody was doing what they were supposed to have done, even a simple mistake as in me thinking that this patient belonged to a ambassador that he didn't.' You continued 'I'm held responsible or accountable for a mistake, a simple mistake, that anybody could have made, whereas people that just disregarded their duties altogether and didn't even do their job….weren't'.

19. Sharpe Policy 45.802, the Hand-off Communication Policy, is apparently the only written policy that specifically mentions patient hand-offs. Yet, it only mentions hand-off communication obligations rather than any obligation to hand-off a patient. This Hand-off Communication Policy was not cited in the disciplinary letter.

20. Policy 45.802 states that the purpose of the policy is "[t]o provide accurate information about a patient's care, treatment, or service when responsibilities are "hand[ed]-off" from one care provider to another." This policy does not define "hand-off" or mandate if or when a "hand-off" must occur. It only hints at the need for a hand-off in

differentiating the types of instances necessitating a "full Report" versus a "Hand-off Communication."

21. Policy 45.802 states that a "full Report" "will be given … [w]hen a provider transfers a patient to another unit." It does not define "provider." The policy also states that "Hands-off [sic] Communication" "will be given… [w]hen patients are being transported to medical appointments or community integrations" or "[w]hen a patient is escorted to an individual or group activity (treatment mall)."

22. Under the heading of "Hand-Off Report," Policy 45.802 states that "[t]he staff member transporting the patient to the Treatment Mall or other group activity will provide the receiving staff a brief description of the patient's physical/psychological condition or other identified concerns if there are any changes since morning report."

23. Respondent never accused Grievant of failing to report a hand-off, be it via a "full Report," "Hands-Off Communication," or "brief description" to receiving staff.

24. Nor has Grievant ever been disciplined for failing to hand-off a patient despite regularly failing to hand-off his patients and failing to verbalize hand-offs.

25. The disciplinary letter does not accuse Grievant of failing to hand-off a patient.

26. Grievant has since participated in review training with HR Director Cecil Pritt regarding the patient hand-off policy.

Discussion

The grievant bears the burden of proof in a grievance that does not involve a disciplinary matter and must prove his grievance by a preponderance of the evidence. W. VA. CODE ST. R. § 156-1-3 (2018). In disciplinary matters, the burden of proof rests with the

employer to prove that the action taken was justified, and the employer must prove the charges against an employee by a preponderance of the evidence. W. VA. CODE ST. R. § 156-1-3 (2018). "The preponderance standard generally requires proof that a reasonable person would accept as sufficient that a contested fact is more likely true than not." *Leichliter v. Dep't of Health & Human Res.*, Docket No. 92-HHR-486 (May 17, 1993), *aff'd*, Pleasants Cnty. Cir. Ct. Civil Action No. 93-APC-1 (Dec. 2, 1994). Where the evidence equally supports both sides, the employer has not met its burden. *Id*.

In its disciplinary letter, Sharpe cited Grievant for patient neglect as justification for his five-day unpaid suspension. Yet, the only factual allegation cited was that, after a therapy session with Grievant, "the patient was observed walking away unescorted back to his unit." Respondent now contends that Grievant had an obligation to maintain custody of Patient CC until verbalizing a hand-off to an ambassador or hall-monitor, and that responsibility for the patient does not transfer until the transfer is verbalized.

Grievant does not contest the factual allegations concerning Patient CC and concedes that he never verbalized a hand-off. However, Grievant contends the hand-off communication policy was vague and unclear and rife with inconsistencies. Grievant claims he never received the written hand-off policy and that, until this incident, Sharpe rarely abided by the hand-off policy. Grievant argues that the hall-monitor would have been responsible for taking custody of Patient CC and that no verbalization was needed. Grievant claims that Sharpe singled him out for enforcement and did not discipline anyone else for doing the same.

The disciplinary letter cites policies on employee conduct and neglect but does not cite any policy covering hand-offs. Respondent now argues that Grievant violated the hand-

off policy and, for the first time, referenced the hand-off communication policy as the only document specifying Grievant's hand-off duties. Yet, the hand-off communication policy only covers what is to be communicated during certain types of hand-offs but does not set forth a duty to hand-off or provide circumstances that would give rise to a duty to hand-off. Respondent also, for the first time, accuses Grievant of violating an email directive to hand-off patients predating the incident.

It should be noted that the disciplinary letter is the charging document for employee discipline. Employers are generally limited to the charges they set forth in disciplinary letters. Thus, the later charge that Grievant violated an emailed "hand-off" directive must be disregarded. The charge of violating a hand-off policy, even though not in the disciplinary letter, is more directly related to the stated charge of patient neglect, so will be allowed. Regardless, both of the belated charges must fail on their merits because Respondent failed to prove insubordination[6] or a violation of the Hand-Off Communications Policy. The evidence does not show Sharpe's email was a hand-off order (just notice of a one-time change in hand-off location) or that the Hand-Off Communications Policy obligated Grievant to hand-off Patient CC.

As for "neglect," Sharpe Sharpe Policy 45.034 defines "neglect" as:

> Actions of omission or commission within the meaning of W.Va. Code § 9-6-1(3), that violate 42 C.F.R. § 482.13, or that constitute a breach of the applicable standard of care, including

[6]"[F]or there to be 'insubordination,' the following must be present: (a) an employee must refuse to obey an order (or rule or regulation); (b) the refusal must be wilful; and (c) the order (or rule or regulation) must be reasonable and valid." *Butts v. Higher Educ. Interim Governing Bd.*, 212 W. Va. 209, 212, 569 S.E.2d 456, 459 (2002) (*per curiam*). The Grievance Board has further recognized that insubordination "encompasses more than an explicit order and subsequent refusal to carry it out. It may also involve a flagrant or willful disregard for implied directions of an employer." *Sexton v. Marshall Univ.*, Docket No. BOR2-88-029-4 (May 25, 1988), aff'd, *Sexton v. Marshall Univ.*, 182 W. Va. 294, 387 S.E.2d 529 (1989).

the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

a. W.V. Code. §9-6-1(3) – The unreasonable failure by a hospital employee or contract staff to provide the care necessary to maintain the safety or health of a patient or that results in the self-neglect of a patient, including the use of undue influence by a hospital employee or contract staff the causes or contributes to self-neglect;

b. 42 C.F.R. § 482.13 – The failure to provide goods and services that are necessary to avoid a patient's physical harm, mental anguish, or mental illness.

c. Breach of the standard of care for the treatment of a patient.

While Sharpe is entitled to define "neglect" however it chooses, West Virginia Code § 9-6-1(4) uses slightly different language from that erroneous attributed by Sharpe policy to § 9-6-1(3) in stating, "'Neglect' means the unreasonable failure by a caregiver to provide the care necessary to maintain the safety or health of a vulnerable adult or self-neglect by a vulnerable adult, including the use of undue influence by a caregiver to cause self-neglect."

However, even though the policies covering "neglect" are nebulous, Respondent showed that "the standard of care" or standard unwritten practice at Sharpe was to ensure patients were always monitored when not in their rooms. This obviously correlates to patient safety. There does not appear to be any dispute regarding this general representation of policy. The dispute rests in the details. Respondent contends that Grievant violated policy in not verbalizing his hand-off. Respondent failed to prove this verbalization requirement was part of any written policy.

Various employees testified that it was standard practice to verbalize hand-offs. Grievant disputes this. The undersigned will avoid the temptation to do a credibility assessment to ferret out this issue, as the answer is in plain sight. It is uncontested that

Grievant rarely handed off patients, let alone verbalized hand-offs. When it comes to an unwritten policy, the imperative is on the employer to ensure the employee understands the intricacies of the policy because unwritten policy can be prone to fluidity. It does not appear that Grievant contests that proper patient care requires that patients always be monitored. However, the devil is in the details. There is no evidence that Grievant knew there was a specialized ritual to patient "hand-offs" that required verbalization, as there is no evidence that Grievant (prior to this incident) had ever verbalized a hand-off, had ever been told he needed to verbalize hand-offs, or that any policy required him to verbalize a hand-off, let alone that he had received such a policy.

It is also revealing that after the incident, Grievant received training on the hand-off policy. The existence of a written hand-off and verbalization policy would have obviated the need for further training and would have been sufficient in and of itself to justify the discipline enacted if it had reflected Respondent's position on the supposed policy. While there is no requirement that hand-offs and the attendant verbalization be part of a written policy, it certainly would be easier for Respondent to prove any verbalization requirement and employee knowledge of protocol if it was part of a written policy. If verbalization was as important as Respondent claims, Respondent would not only have enforced prior violations but would also have included the hand-off and associated verbalization requirement in its written Hand-Off Communication Policy. The irony is that nothing prevents Sharpe from rewriting Policy 45.802 to actually require employees to hand-off patients and require verbalization of patient hand-offs. There is no evidence that Sharpe has contemplated including hand-off and verbalization requirements in its written policy.

Further, Grievant contends that in the past hall monitors would take his patients without his need to verbalize a hand-off. Thus, it would not have been unreasonable of him, under the definition of neglect, to assume the same would have transpired on the occasion at issue. While Respondent proved that as a matter of protocol it is neglect to leave a patient unattended, Respondent did not prove by a preponderance of the evidence that it was justified in suspending Grievant without pay for five days for failing to verbalize a patient hand-off. Respondent did not meet its burden of proving that its unpaid suspension of Grievant for five days was justified.

As for the remaining claim, Grievant failed to prove a hostile work environment. The point at which a work environment becomes hostile or abusive does not depend on any "mathematically precise test." *Harris v. Forklift Systems, Inc*., 510 U.S. 17, 22, (1993). Instead, "the objective severity of harassment should be judged from the perspective of a reasonable person in the plaintiff's position, 'considering all the circumstances.'" *Oncale v. Sundowner Offshore Servs., Inc*., 523 U.S. 75 (1998) (*citing Harris*, 510 U.S. at 23). These circumstances "may include the frequency of the discriminatory conduct; its severity; whether it is physically threatening or humiliating, or a mere offensive utterance; and whether it unreasonably interferes with an employee's work performance" but "no single factor is required." *Harris*, 510 U.S. at 23. "To create a hostile work environment, inappropriate conduct must be sufficiently severe or pervasive to alter the conditions of an employee's employment. *See Hanlon v. Chambers*, 195 W. Va. 99, 464 S.E.2d 741 (1995)." *Napier v. Stratton*, 204 W. Va. 415, 513 S.E.2d 463, 467 (1998) (*per curiam*). "As a general rule 'more than a few isolated incidents are required' to meet the pervasive requirement of proof for a hostile work environment case. *Kimzey v. Wal-Mart Stores, Inc*., 107 F.3d 568, 573 (8th Cir.

1997)." *Fairmont Specialty Servs. v. W. Va. Human Rights Comm'n*, 206 W. Va. 86, 96, 522 S.E.2d 180, 190 n.9 (1999).

The only inappropriate conduct alleged by Grievant was discrimination, in that Respondent did not punish other employees who left patients unattended and unescorted. Discrimination for purposes of the grievance process has a very specific definition. "'Discrimination' means any differences in the treatment of similarly situated employees, unless the differences are related to the actual job responsibilities of the employees or are agreed to in writing by the employees." W. VA. CODE § 6C-2-2(d). Grievant did not identify these unpunished employees so it could be determined whether they were similarly situated to Grievant. Grievant thus failed to prove discrimination and hostile work environment. Thus, this grievance is GRANTED, in part, and DENIED in part.

The following Conclusions of Law support the decision reached.

Conclusions of Law

1. The grievant bears the burden of proof in a grievance that does not involve a disciplinary matter and must prove his grievance by a preponderance of the evidence. W. VA. CODE ST. R. § 156-1-3 (2018). The burden of proof in disciplinary matters rests with the employer to prove by a preponderance of the evidence that the disciplinary action taken was justified. W. VA. CODE ST. R. § 156-1-3 (2018). "The preponderance standard generally requires proof that a reasonable person would accept as sufficient that a contested fact is more likely true than not." *Leichliter v. Dep't of Health & Human Res.*, Docket No. 92-HHR-486 (May 17, 1993), *aff'd*, Pleasants Cnty. Cir. Ct. Civil Action No. 93-APC-1 (Dec. 2, 1994). Where the evidence equally supports both sides, the employer has not met its burden. *Id*.

2. Respondent failed to prove by a preponderance of the evidence that its unpaid suspension of Grievant for five days was justified.

3. Grievant failed to prove a hostile work environment by a preponderance of the evidence.

Accordingly, this grievance is **GRANTED,** in part**, and DENIED,** in part. Respondent is **ORDERED** to provide Grievant back pay for the five days he was suspended without pay, plus interest at the statutory rate; to restore all benefits, including seniority; and to remove all references to the suspension from Grievant's personnel records maintained by Respondent.

"The decision of the administrative law judge is final upon the parties and is enforceable in the circuit court situated in the judicial district in which the grievant is employed." W. VA. CODE § 6C-2-5(a) (2024). "An appeal of the decision of the administrative law judge shall be to the Intermediate Court of Appeals in accordance with §51-11-4(b)(4) of this code and the Rules of Appellate Procedure." W. VA. CODE § 6C-2-5(b). Neither the West Virginia Public Employees Grievance Board nor any of its Administrative Law Judges is a party to such an appeal and should not be named as a party to the appeal. However, the appealing party must serve a copy of the petition upon the Grievance Board by registered or certified mail. W. VA. CODE § 29A-5-4(b) (2024).

Date: February 5, 2025

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Joshua S. Fraenkel
Administrative Law Judge