Effective 10/01/2007

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

August 24, 2007

Catherine Lah
[redacted]

RE: MDH File Number: SPC20047

Dear Ms. Lah:

Based on the facts and law in this matter as described in the enclosed Staff Determination, the Minnesota Department of Health has determined that you performed services of a speech-language pathologist (SLP) in an incompetent or negligent manner, and you have engaged in conduct likely to deceive, defraud, or harm the public; or demonstrated a willful or careless disregard for the health, wealth, or safety of a client in violation of Minnesota Statutes, section 148.5195, subdivision 3(3) and 3(11). Therefore, you are being assessed a disciplinary civil penalty in the amount of $743.00. Additionally, your practice as a Speech Language Pathologist must be supervised for a period of twelve months, and you shall successfully complete a continuing education class within twelve months in ethics, boundaries or a similar class as approved by the Department. This disciplinary action is authorized by Minnesota Statutes, section 148.5195, subdivision 4.

This decision will be made final and effective 30 days from the date it is received by you. During that 30-day period, you have the right to challenge this decision in a contested-case hearing, as provided under Minnesota Statutes, Chapter 14. Requests for a hearing should be made in writing and include specific grounds for challenging the Department's decision. If you wish to request a hearing, please send a written hearing request, within 30 days of your receipt of this letter, to:

Susan Winkelmann, Investigations and Enforcement Manager
Minnesota Department of Health
PO Box 64882
Saint Paul, MN 55164-0882

You may also deliver your request to 85 East Seventh Place, Suite 220, Saint Paul, MN; or fax it to Ms. Winkelmann at (651) 201-3839. If you have any questions about this matter, please contact Catherine Dittberner Lloyd at (651) 201-3706.

Sincerely,

Darcy Miner

Darcy Miner, Director
Compliance Monitoring Division

Enclosure

cc: Tom Hiendlmayr, Director of the Health Occupations Program
Susan Winkelmann, Manager, Investigations and Enforcement Unit

HEALTH OCCUPATIONS PROGRAM
MINNESOTA DEPARTMENT OF HEALTH

A Determination In the Matter of Catherine Lah
Speech Language Pathologist Practitioner

AUTHORITY

1. Minnesota Statutes, section 148.5195, subdivision 3(3), prohibits performing services of a speech-language pathologist (hereinafter "SLP) in an incompetent or negligent manner.

2. Minnesota Statutes, section 148.5195, subdivision 3(11) prohibits engaging in conduct likely to deceive, defraud, or harm the public; or demonstrating a willful or careless disregard for the health, wealth, or safety of a client.

3. Minnesota Statutes, section 148.5195, subdivision 4 authorizes the Department to take disciplinary action against practitioners who violate Minnesota Statutes, section 148.5195, subdivision 3, including refusing to grant or renew licensure, suspension, revocation, taking any reasonable lesser action, and imposing a civil penalty for each violation not exceeding $10,000 that deprives the licensee of any economic gained by the violation and that reimburses the Department for the costs of the investigation and proceedings resulting in disciplinary action.

FINDINGS OF FACT

1. Catherine Lah (hereinafter "Practitioner") has been a registered and licensed SLP since September 10, 1996.

2. Practitioner has been subject to two public actions. Effective July 24, 2000, the Department determined Practitioner illegally used a protected title associated with SLP in violation of Minnesota Statutes, section 148.513 from April 1, 1998 to September 2, 1998 when she continued to use SLP protected titles after her registration expired on March 31, 1998. Practitioner was issued a civil penalty of $89.00. Effective February 1, 2002, the Department determined Practitioner illegally used protected titles associated with SLP from June 1, 2001, to June 14, 2001 when she continued to work and use protected titles after her registration expired on May 31, 2001. Practitioner was issued a civil penalty of $165.00.

3. On August 22, 2001, Client 1, a 31 year old male, was admitted to Nursing Home A and was receiving treatment for a traumatic brain injury related to alcoholism which had occurred on June 11, 1001. Practitioner provided speech-language services to Client 1 five times per week from August 24, 2001 to December 31, 2001, as per the plan of care. Goals of therapy included improvement in reading comprehension, written language skills, memory and cognition. Practitioner was aware of Client 1's medical condition and needs through consultation with Client 1's physician, nursing staff and upon review of Client 1's medical charts. Practitioner

billed for services through Nursing Home A to Medical Assistance. On December 31, 2001, Client 1 completed his speech-language therapy because the goals were attained. Client 1 was discharged from Nursing Home A on May 1, 2002.

4. Subsequent to providing services to Client 1, on April 11, 2002 and on April 15, 2002, Practitioner signed Client 1 out of Nursing Home A which caused Client 1 to miss medications and miss scheduled meetings with family members. Practitioner took Client 1 to establishments that served alcohol and discussed personal problems with Client 1. Client 1 told Practitioner that his probation officer (hereinafter "Probation Officer") told Client 1 not to go into bars that served only alcohol but he could to go into establishments that served food and alcohol.

5. Practitioner told the Department that she provided no further speech-language services for Client 1 after December 31, 2001 and that while she was Client 1's therapist, she did not share personal information with him. Practitioner told the Department that Client 1 was "his own guardian" and was able to sign himself out of the facility independently. Practitioner told the Department that Client 1's family and nursing staff requested that Client 1 not leave the facility alone due to a recent onset of grand mal seizures due to the traumatic brain injury. Practitioner did not state where she took Client 1 prior to the April 15, 2002 outing, but only stated she was aware that Client 1 was not to go into bars and pubs due to a history with alcoholism. Practitioner believed she complied with this because she took Client 1 to establishments that served food and alcohol to play pool, play darts and eat. Practitioner A did not provide the dates and times she took Client 1 out of the facility, but stated as per Client 1's wishes, she took Client 1 to visit mutual friends, go to lunch, go to shop, visit the library and frequently shoot pool and play darts. Practitioner believed Client 1 was successful at these activities. Practitioner stated Client 1 informed the staff at Nursing Home A about his activities and took his medications with him on the outings. Practitioner stated on April 15, 2002, Client 1 missed his 4:00 p.m. pain medication, but this medication was to be taken on an as-needed basis. On April 15, 2002, Practitioner stated Client 1 called his family to cancel their 5:00 p.m. scheduled visit because he was going out to dinner with Practitioner. Practitioner stated she spoke "frequently and openly" with the facility staff and Client 1's family about their activities and about befriending Client 1. Practitioner believed it was helpful for Client 1 to get out of the facility frequently because the process of discharging Client 1 to a supervised apartment was taking a long time. Practitioner was aware that Client 1's physician believed it was in Client 1's best interest to remain at the nursing home because of the seizures and belief that Client 1 would start drinking again. Practitioner stated she has befriended other residents of the facility and took other residents on outings with her family, and on her own time. Practitioner stated the complaint arose from the "rumor mill" because she was going through a divorce and because of Client 1's age. Practitioner believed it was not healthy for Client 1 to sit in his room with "nothing to do" until his discharge in May, 2002 and she did not believe Client 1's friends and family provided appropriate activities and only took him out of the facility on weekends. Practitioner stated she remains a friend to Client 1 where he now resides in an apartment.

6. On July 19, 2002, the Department obtained information from Practitioner's employer (hereinafter "Health Care Center B") regarding Practitioner's employment. Health Care Center B provided the following:

a. Practitioner began employment on a temporary basis on November 1, 2000 and began permanent part time employment on April 2, 2002 as an SLP.

b. In late February or early March of 2002, Nursing Home A received a complaint regarding a potential vulnerable adult violation relating to Practitioner's behavior with Client 1. Nursing Home A requested that Practitioner refrain from any contact with Client 1 until after the investigation and advised Health Care Center B that Practitioner was not to provide speech-language therapy services to other patients at the facility until the investigation was complete. Health Care Center B informed Practitioner of the pending investigation and directed she have no contact or provide services to clients at Nursing Home A.

c. On March 13, 2002, Nursing Home A informed Health Care Center B they found no evidence of a vulnerable adult violation. Nursing Home A stated Practitioner would be able to continue to provide speech-language therapy services to patients and to continue her relationship with Client 1 under certain conditions. On March 19, 2002, Health Care Center B informed Practitioner, and the Practitioner agreed, to the following conditions as set forth by the Nursing Home A:

    i. Practitioner refrain from direct physical contact (hugging)

    ii. Practitioner maintain professional distance (not sitting on the bed beside the Client 1 in his room)

    iii. Keep the door open when visiting Client 1 in his room

    iv. Proceed with caution with her relationship with Client 1

    v. Do not to take Client 1 out to places that serve alcohol.

d. In late March or early April 2002, Nursing Home A received another complaint that Practitioner took Client 1 to an eating establishment that served alcohol and that Practitioner exhibited secretive behavior when she asked another employee of Nursing Home A to "escort" Client 1 out of the facility and into Practitioner's vehicle. On April 19, 2002, Nursing Home A barred Practitioner from providing speech-language services on a permanent basis.

e. On May 30, 2002, Health Care Center B issued Practitioner notice of a one-day suspension for gross misconduct. Practitioner served the suspension on July 17, 2002. Specific reasons for the suspension included:

    i. After specific warnings, Practitioner entertained a resident of Nursing Home A

    ii. Practitioner took Client 1 to an establishment that served alcohol after being told not to

iii. The insubordinate behavior caused harm to a business relationship with the nursing home and caused staffing problems when the nursing home refused to allow Practitioner to provide further services.

iv. Such misconduct that causes harm to a client relationship or could cause harm to a resident of client, or an error in judgment that places a patient at risk may result in further discipline

v. Practitioner's misconduct could result in action taken under the Minnesota Vulnerable Adult Act.

7. On January 13, 2003, Practitioner told the Department she had never been subject to an investigation or corrective order resulting from an investigation concerning her practice as an SLP, and had never been suspended or barred from performing services as an SLP. In response to the Department's questions about how Practitioner could tell the Department that she had never been disciplined, Practitioner told the Department she did not believe she was subject to any disciplinary action regarding her license as an SLP because the conduct with Client 1 occurred after her speech-language pathology serves concluded.

8. On April 8, 2003, Client 1's physician told the Department Client 1's health or welfare would not have been compromised if his lubricating eye drops were missed or delayed [when Practitioner took Client 1 out of Nursing Home A]. However, Client 1 was also on Neurontin and Depakote, which were to be given three times per day and delay of giving these medications potentially could make Client 1 more prone to a breakthrough seizure for which the medicines were being prescribed. The medications were ordered at 8:00 a.m., 12:00 noon, and 8:00 p.m. If Client 1 left the facility before noon, he would have missed the noon dose.

9. On May 12, 2003, the Department presented the preliminary issues in the case to Speech-Language Pathologist members of the Speech-Language Pathologist and Audiologist Advisory Council Competency Review Committee (hereinafter "CRC"). CRC members stated it is appropriate to take a client on social outings, also referred to "community integration," when working with the client on communication skills; however this type of treatment is more often done with groups of clients. CRC members were not concerned about taking a 31-year old male out, but were concerned about the one-on-one outing and believed Practitioner was naïve regarding her responsibilities as a therapist to maintain boundaries. CRC members believed it was inappropriate when Practitioner hugged Client 1 and it was inappropriate when Practitioner took Client 1 out of the facility after she was specifically told not to and because Practitioner was still providing services to other clients at the facility. CRC members believed Client 1 likely had impaired judgment due to the brain injury. CRC members requested the Department review all of Practitioner's employment records relating to her practice as an SLP.

10. The Department obtained employment records from two additional employers. No other disciplinary actions related to Practitioner's employment as a licensed SLP were noted in the records.

11. On March 6, 2007, the Department again presented the issues in the investigation to Speech-Language Pathology members of the Speech-Language Pathologists and Audiologists Advisory Council CRC. CRC members recommended Practitioner be supervised and take continuing education classes in issues related to boundaries.

CONCLUSION

Practitioner did not comply with the requirements of Minnesota Statutes, sections 148.5195, subdivisions 3(3) and 3(11).

DETERMINATION

1. Practitioner should pay a civil penalty of $743.00, representing the costs of the investigation to date.

2. Practitioner must provide any employer who hires her as an SLP with a copy of this Determination.

3. Practitioner's practice as an SLP must be supervised for a period of twelve (12) months by one supervisor in the following activities: daily and weekly treatment plans, review of current and upcoming problems and concerns, Practitioner's relationship with clients.

4. Practitioner's supervisor must submit monthly reports to the Department for the first three (3) months of the twelve months to report about Practitioner's treatment plans, problems or concerns, and relationship with clients. Thereafter, Practitioner's supervisor can submit one report every three months for the final three quarters of the twelve-month period. If Practitioner obtains a new supervisor during the twelve-month supervision period, the new supervisor must provide monthly reports for the first three months directly to the Department and thereafter resume the schedule of quarterly reports until the twelve month period is completed.

5. Practitioner shall sign whatever releases are necessary for the supervisor to report Practitioner's work directly to the Department. Practitioner shall cooperate fully during the process of the Department's enforcing and monitoring compliance with this Determination.

6. Within twelve months, Practitioner shall successfully complete a continuing education class in ethics, boundaries, or a similar class as approved by the Department. This class shall be a minimum of two contact hours and shall be in addition to the continuing education requirements of Minnesota Statutes, section 148.5193.