Compilation of Codes, Rules and Regulations of the State of New York
Title 14. Department of Mental Hygiene
Chapter XIII. Office of Mental Health
Part 524. Incident Management Programs

(Statutory authority: Mental Hygiene Law §§7.07, 7.09, 7.21, 29.29, 31.11, 31.16, 33.23, 33.25; Executive Law §§556, 557; Social Services Law §§490, 491, 492)

Sec.

524.1 Background and intent

(a) The purpose of this Part is to ensure that providers of mental health services develop and implement effective incident management programs in order to protect the health and safety of patients and enhance their quality of care. Incident management programs include the components of effective abuse protection; the classification of incidents; tracking and trending of incidents; and implementing effective actions to protect individuals served from harm.

(b) It is the expectation of the Office of Mental Health that providers of mental health services under its jurisdiction will afford their patients appropriate services in a caring and hospitable environment that is recovery-oriented and free from harm. In order to create this environment, providers must seek to eliminate, wherever possible, the occurrence of incidents, i.e., episodes of harm or potential harm. This Part thus requires providers to assure that any reportable incidents are reported and analyzed, and the appropriate corrective, remedial, or disciplinary action occurs, in accordance with applicable federal or state law and regulations.

c) Incident management programs must also incorporate principles of clinical risk management, which emphasize the improvement of systems and processes. Clinical risk management involves review of incident patterns and trends to identify the facts, circumstances, processes, systems, and areas of risk that may have contributed to such incidents in order to identify opportunities for performance improvement.

524.2 Legal base

(a) Section 7.07 of the Mental Hygiene Law gives the Office of Mental Health the responsibility for seeing that persons with mental illness are provided with care and treatment, that such care, treatment and rehabilitation is of high quality and effectiveness, and that the personal and civil rights of persons receiving care, treatment, and rehabilitation are adequately protected.

(b) Section 7.09 of the Mental Hygiene Law grants the Commissioner of the Office of Mental Health the power and responsibility to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction and to set standards of quality care.

(c) Subdivision (b) of Section 7.21 of the Mental Hygiene Law requires directors of facilities operated by the Office of Mental Health to investigate, or cause to be investigated, every reportable incident in accordance with Article 11 of the Social Services Law, and to require allegations of abuse and neglect and significant incidents to be reported to the Vulnerable Persons' Central Register. Directors of facilities must also notify the Vulnerable Persons' Central Register if it appears that a crime may have been committed and such Register shall notify law enforcement as appropriate. Pursuant to this Section, the Vulnerable Persons' Central Register must notify the Board of Visitors and the Mental Hygiene Legal Service of every complaint of abuse or neglect and the results of all related investigations.

(d) Section 29.29 of the Mental Hygiene Law requires the establishment of uniform standards and procedures for the compilation and analysis of incident reports in facilities operated by the Office of Mental Health.

(e) Section 31.11 of the Mental Hygiene Law requires programs licensed by the Office of Mental Health to notify the district attorney or other law enforcement official and the Commissioner or his or her authorized representative if it appears that a crime may have been committed against a patient.

(f) Section 31.16 of the Mental Hygiene Law provides that the Commissioner of the Office of Mental Health may impose a fine upon a finding that the holder of an operating certificate has failed to comply with the provisions of any applicable statute, rule, or regulation.

(g) Section 33.23 of the Mental Hygiene Law requires 24-hour telephone notification of qualified persons, as defined in Section 33.16 of such law, of certain incidents that occur at facilities.

(h) Section 33.25 of the Mental Hygiene Law requires the release of records and documents pertaining to allegations and investigations of abuse or neglect to qualified persons, as defined

in Section 33.16 of the Mental Hygiene Law, upon their request.

(i) Section 556 of the Executive Law provides the Justice Center the authority to make recommendations of preventive and remedial actions to the Office of Mental Health in response to investigations of allegations of abuse or neglect involving patients.

(j) Section 557 of the Executive Law requires that directors of State-operated facilities and directors of licensed programs report deaths of individuals in their care and any allegations of abuse or neglect to the Justice Center.

(k) Article 6, title 6 of the Social Services Law requires the reporting of suspected abuse or neglect by a caretaker in a foster family care, day care, or family setting of persons under 18 years of age to the Statewide Central Register of Child Abuse and Maltreatment.

(l) Section 490 of the Social Services Law requires the Office of Mental Health to promulgate regulations governing the development of incident management programs; such regulations must be approved by the Justice Center as consistent with its standards and guidelines.

(m) Sections 491 and 492 of the Social Services Law require the reporting of allegations of abuse and neglect and significant incidents to the Vulnerable Persons' Central Register.

Section 524.3 Applicability

(a) Providers operated or licensed by the Office: The provisions of this Part apply to all mental health providers operated or licensed by the Office, with the exception of secure treatment facilities established pursuant to Article 10 of the Mental Hygiene Law, and programs operated by the Office which are located in facilities operated by the Department of Corrections and Community Supervision, which shall report, investigate, and review incidents in accordance with policies of the Office.

(b) For providers of mental health services not subject to this Part, the Office may establish incident reporting standards as a term and condition of the receipt of funding from, or other approval by, the Office to provide such services.

(c) This Part is controlling over any other Part of this Title governing the reporting, investigation or review of incidents in those mental health facilities or programs subject to this Part.

Section 524.4 General definitions

As used in this Part:

(a) **Custodian** means:

(1) a director, operator, employee, security personnel, or volunteer of a mental health provider; or

(2) a contractor that performs services pursuant to a contract that permits regular and substantial contact with patients of a mental health provider.

(b) **Discovery** means at the time a Mandated Reporter witnesses an activity which appears to be a reportable incident or when any other person comes before the mandated reporter in their professional or official capacity and provides information that gives the mandated reporter reasonable cause to suspect that a reportable incident has occurred.

(c) **Employee or Staff** means an administrator, employee, consultant, volunteer or student affiliated with a mental health provider as such term is defined in this Section, or a person employed by an entity which has a contract with such a program or provider, but shall not include employees or volunteers who are also patients of the mental health provider.

(d) **First aid** means one-time treatment, and any follow up, of minor scratches, cuts, burns, splinters, or other minor injuries which do not ordinarily require medical care.

(e) **Incident** means an event, involving a patient who receives services provided by a mental health provider which has, or creates a risk of, an adverse effect on the life, health, safety, or welfare of the patient or another person. For purposes of this Part, the term “incident” shall include any incident requiring reporting and investigation under this Part, including Reportable incidents, patient death, and incidents that must be reported to the Office of Mental Health.

(f) **Investigation** means the systematic collection and examination of the information and circumstances surrounding an incident.

(g) **Justice center** means the New York State Justice Center for the Protection of People with Special Needs.

(h) **Local government unit** means the unit of local government given authority in accordance with Article 41 of the Mental Hygiene Law to provide local or unified services.

(i) **Mandated Reporter** means a certain person or professional, identified in subdivision (5) of Section 488 of the Social Services Law, not including a patient, who is required to report allegations of Reportable Incidents to the Vulnerable Persons’ Central Register immediately upon discovery, including:

(1) a custodian; or

(2) a human services professional, including any: physician; registered physician assistant; surgeon; medical examiner; coroner; dentist; dental hygienist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; licensed practical nurse; nurse practitioner; social worker; emergency medical technician; licensed creative arts therapist; licensed marriage and family therapist; licensed mental health counselor; licensed psychoanalyst; licensed behavior analyst,

certified behavior analyst assistant; licensed speech/language pathologist or audiologist; licensed physical therapist; licensed occupational therapist; hospital personnel engaged in the admission, examination, care or treatment of persons; Christian Science practitioner; school official, which includes but is not limited to school teacher, school guidance counselor, school psychologist, school social worker, school nurse, school administrator or other school personnel required to hold a teaching or administrative license or certificate; full or part-time compensated school employee required to hold a temporary coaching license or professional coaching certificate; social services worker; any other child care or foster care worker; mental health professional; person credentialed by the office of alcoholism and substance abuse services; peace officer; police officer; district attorney or assistant district attorney; investigator employed in the office of a district attorney; or other law enforcement official.

(j) **Mental health provider** means a provider or program operated or licensed by the Office of Mental Health.

(k) **Minor injury or harm** means:

(1) physical pain or injury requiring no medical treatment or intervention, or no medical treatment or intervention beyond first aid; or

(2) no apparent psychological harm, or psychological harm that does not require a significant change in psychotropic or psychotherapeutic intervention.

(l) **Office** means the New York State Office of Mental Health, the state oversight agency for mental health providers, as such term is defined in this Section.

(m) **Patient** means an individual who receives services from a mental health provider.

(n) **Qualified person** means any person who may request access to a patient's clinical record in accordance with Section 33.16 of the Mental Hygiene Law.

(o) **Reasonable cause to suspect:** Based on all the evidence, facts, and circumstances known or readily available, it is rational to think a reportable incident may have occurred. Reasonable cause to suspect is a judgment about a statement, not about the condition, competency, or credibility of a patient.

(p) **Reportable Incident** means significant incidents including death, and allegations of abuse and neglect that must be reported to the Justice Center for the Protection of Persons with Special Needs and the Office.

(q) **Restraint** means the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move their arms, legs, head or body.

(r) **Serious injury or harm** means:

(1) physical harm requiring medical treatment or intervention beyond first aid, (including the use of an opioid antagonist (i.e. Narcan/Naloxone) when used to counter the effects of a suspected opioid overdose excluding routine diagnostic tests such as laboratory work, X-rays, or scans if no medical treatment is indicated);

(2) psychological harm evidenced by negative changes in affect, behavior, cognition, or which necessitate a significant change in psychotropic or psychotherapeutic intervention; or

(3) a risk for life threatening physical injury or for psychiatric emergency or trauma

(s) **Human trafficking**, also known as trafficking in persons, means a crime under the penal law that involves compelling or coercing a person to provide labor or services, or to engage in commercial sex acts. The coercion can be subtle or overt, physical, or psychological. Exploitation of a minor for commercial sex is human trafficking, regardless of whether any form of force, fraud, or coercion was used.

(t) **Significant Incident** means a reportable incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety or welfare of a patient.

(u) **Vulnerable Persons' Central Register** means the statewide Vulnerable Persons' Central Register of the Justice Center established pursuant to Section 492 of the Social Services Law.

Section 524.5 Incident category definitions

For purposes of reporting incidents pursuant to Section 524.7 of this Part, the following terms are defined; provided, however, nothing contained herein shall be construed as restricting the discretion of the Justice Center in categorizing incident reports:

(a) **Abuse:** any of the following acts of a custodian:

(1) **Physical Abuse:** intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a patient or causing the likelihood of such injury or impairment; such conduct may include, but is not limited to slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, or the use of corporal punishment, provided, however, that this shall not include reasonable emergency interventions necessary to protect the safety of any person.

(2) **Psychological Abuse:** intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a patient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such

conduct may include, but shall not be limited to, intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments, or ridicule.

(3) **Sexual Abuse:** conduct that subjects a patient to any offense defined in Article 130 (sex offenses) or Section 255.25 (incest, 3rd degree), 255.26 (incest, 2nd degree), or 255.27 (incest, 1st degree) of the Penal Law, or any conduct or communication that allows, permits, uses or encourages a patient to engage in any act described in Articles 230 (prostitution offenses) or 263 (sexual performance by a child) of the Penal Law.

(4) **Deliberate Inappropriate Use of Restraint:**

(i) The application of restraint, as defined in section 526.4 of this Title, shall constitute abuse when such application is deliberately inappropriate. For purposes of this Part, deliberately inappropriate shall mean any use of restraint for any reason other than as an emergency safety intervention.

(ii) The application of restraint shall not constitute abuse when such application is necessary and performed in accordance with applicable laws and regulations.

(iii) In situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed, nothing in this Section shall be construed to prohibit the use of reasonable physical force when necessary to protect the life and limb of any person.

(5) **Obstruction of reports of Reportable Incidents:** conduct that impedes the discovery, reporting or investigation of treatment of a patient by falsifying records related to the safety, treatment or supervision of a patient, actively persuading a Mandated Reporter from making a report of a reportable incident to the Statewide Vulnerable Persons' Central Register with the intent to suppress the reporting or the investigation of an incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report in accordance with governing state agency regulations, policies, or procedures; intentional failure of a supervisor or manager to act upon such a report, or failure by a Mandated Reporter to report a reportable incident upon discovery, (unless the report is made in accordance with the provisions of section 524.8(e) of this Part).

(6) **Unlawful use or administration of a controlled substance:** any administration to a patient of a controlled substance, as defined by Article 33 of the Public Health Law without a lawful prescription, or other medication not approved for any use by the federal Food and Drug Administration, and/or unlawful use or distribution of a controlled substance as defined by Article 33 of the Public Health Law at the workplace or while on duty.

(7) **Aversive conditioning:** the use of unpleasant physical stimulus to modify behavior without person-specific legal authorization, provided, however, that any use of aversive conditioning is prohibited in facilities under the jurisdiction of the Office.

(b) **Assault:** a violent or forceful physical attack by a person other than a custodian, in which a patient is either the victim, or aggressor, and which results in serious injury or harm.

(c) **Choking:** An event where a patient is unable to breathe as a result of ingestion of food or other foreign object which requires a physical intervention (i.e. Heimlich Maneuver);

(1) that results in serious injury or harm or admission to a hospital; or

(2) where there is a written directive for such patient concerning risk of choking in place at the time of the event.

(d) **Crime:** an event which is or appears to be a crime under New York State or Federal law, which occurs on program premises or when a patient is under the actual or intended supervision of a custodian, and which involves a patient as a victim, or which affects or has the potential to affect the health or safety of one or more patients of the program or has the potential to have a significant adverse impact on the property or operation of the program. For the purposes of this Part, crimes shall include acts committed by persons less than 18 years of age which, if committed by an adult, would constitute a crime.

(e) **Crimes in the Community:** an event which is, or appears to be, a crime under New York State or Federal law, and which is perceived to be a significant danger to the community, or which involves a patient whose behavior poses an imminent concern to the community.

(f) **Falls by patients:** events where patients trip, slip, or otherwise fall while in an inpatient or residential setting, resulting in serious injury or harm.

(g) **Fight:** a physical altercation between two or more patients, in which there is no clear aggressor and no clear victim, resulting in serious injury or harm.

(h) **Financial exploitation:** Use, appropriation, or misappropriation by a custodian of a patient's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the patient of those resources. Examples include the deliberate misplacement, theft, or wrongful, temporary, or permanent use of a patient's belongings or money.

(i) **Fire setting:** action by a patient of a mental health provider, either deliberate or accidental, that results in fire on program premises.

(j) **Inappropriate use of restraint or seclusion:**

(1) use of restraint, as defined in section 526.4 of this Title, that is inappropriate because it was implemented without a valid physician's order or in a manner that was otherwise not compliant with applicable State or Federal regulations, but which does not rise to the level of physical abuse, as defined in this section; or

(2) use of seclusion, as defined in section 526.4 of this Title, that was unauthorized because it was implemented without a valid physician's order or in a manner that was otherwise not compliant with applicable State or Federal regulations.

(k) **Injury of unknown origin:** an injury to a patient for which a cause cannot be immediately determined because:

(1) the source of the injury was not observed by any person, or the source of the injury could not be explained by the patient or other person; and

(2) the injury is suspicious because of the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the frequency of the incidence of injuries over time.

(l) **Human trafficking - off site:** A patient of an inpatient or residential youth program, while on authorized leave or pass from the program, is the victim of human trafficking.

(m) **Medication error:** an error in prescribing, dispensing, or administering a drug which results in serious injury or harm.

(n) **Missing patient:**

(1) A patient of an inpatient or residential program:

(i) who has not been accounted for when expected to be present (in accordance with facility or program practice or policies) and who has not been found on the facility grounds or other expected location; or

(ii) who is known to have left the facility grounds without the permission of an employee, when such permission is otherwise required and who is considered dangerous to others or unable to care for themselves; or

(iii) who has not been accounted for when expected to be present and while missing was a victim of human trafficking.

(2) a patient of an outpatient mental health program who is under the age of 18, and whose whereabouts are not accounted for when expected to be present or under the supervision of an employee.

(o) **Missing subject of AOT order:** A person subject to an assisted outpatient treatment (AOT) order who fails to keep a scheduled appointment and/or who cannot be located within a 24-hour period.

(p) **Neglect:** any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a patient. Neglect shall include, but is not limited to:

(1) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse if committed by a custodian;

(2) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations of the Office, provided that the mental health provider has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; and

(3) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of Part One of Article 65 of the Education Law and/or the patient's individualized education program.

(q) **Other Incident:** An event, other than one identified in this section, which has or creates a risk of serious injury or harm.

(r) **Overdose:** When a patient consumes an amount of a substance (e.g., prescription, over-the-counter, legal, or illegal) which is not intended to cause their own death, but results in serious injury or harm.

(s) **Self-abuse:** self-inflicted injury not intended to result in death that results in serious injury or harm.

(t) **Severe adverse drug reaction:** an unintended, unexpected, or excessive response of a patient to a medication that occurs at doses normally used in patients for prophylaxis, diagnosis or therapy of disease, or for the modification of physiologic function and which:

(1) results in transfer to an emergency room, admission to a medical facility, or a longer hospital stay;

(2) requires intervention to prevent permanent impairment;

(3) results in permanent disability;

(4) results in congenital anomaly (birth defect);

(5) is life threatening; or

(6) results in death.

(u) **Sexual assault:**

(1) nonconsensual sexual conduct including the deliberate touching of a patient's intimate body parts, or clothing covering those body parts, or using force to cause self-touching by another patient of intimate body parts, or contact that results in vaginal, anal, or oral penetration, i.e., rape or attempted rape and sodomy or attempted sodomy; or

(2) any sexual conduct between a person who is 18 years old or more and a person who is less than 15 years old, or between a person who is 21 years of age or older and a person who is less than 17 years old; or

(3) any sexual conduct which involves a patient who is deemed incapable of consent.

(v) **Sexual contact between children:** vaginal, anal, or oral penetration by patients under age 18.

(w) **Suicide attempt:** an act committed by a patient of a mental health provider in an effort to cause their own death that occurs on program premises or when the patient was under the actual or intended supervision of a custodian.

(x) **Suicide attempt, Off Site:** an act committed by a patient of a mental health provider in an effort to cause their own death that occurs off program premises, when the patient was not under the actual or intended supervision of a custodian.

(y) **Verbal Aggression by Parents:** a sustained, repetitive action or pattern by a patient or patients of ridiculing, bullying, demeaning, making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on another patient or patients, which causes serious injury or harm.

(z) **Wrongful Conduct:** Actions or inactions on the part of a custodian that are contrary to sound judgment or training and which are related to the provision of services, the safeguarding of patient health, safety, or welfare, or patient rights, but which do not meet the definition of abuse or neglect, including but not limited to:

(1) any non-accidental physical contact with a patient which causes minor injury or has the reasonably foreseeable potential to cause injury, provided however that this shall not include the application of restraint, when such application is necessary and performed in accordance with applicable laws and regulations, or reasonable emergency interventions necessary to protect the safety of any person;

(2) intentional verbal or nonverbal conduct that is meant to cause a patient emotional distress, but which does not result in harm, or results in only minor harm, to the patient. Examples include taunting, name calling, issuing threats, using insulting, disrespectful, or coarse language or gestures directed toward a patient; violating patient rights or misusing authority;

(3) activity of a sexual nature (physical or non-physical) involving a patient and a custodian; or activity of a sexual nature involving a patient that is encouraged by a custodian. Examples include inappropriate touching or physical contact, sending sexually explicit materials through electronic means (including but not limited to mobile phones, electronic mail, and social media), voyeurism, or sexual exploitation; or

(4) conduct that falls below the standards of behavior established in regulations or facility policies and procedures for the protection of patients against unreasonable risk of harm;

(5) removal of a patient from regular programming and isolate them in an area for the convenience of a custodian or as a substitute for programming; or

(6) any intentional administration to a patient of a prescription drug or over-the- counter medication which is not in substantial compliance with a physician's, dentist's, physician's assistant's, specialist's assistant's, or nurse practitioner's prescription.

Section 524.6. Incident management program

(a) Consistent with the requirements of this Part, all mental health providers shall develop, implement and monitor the effectiveness of an incident management program, with the intent of protecting the health and safety of patients and enhancing their quality of care.

(b) At a minimum, incident management programs shall consist of the following components:

(1) Organization and administration. Mental health providers shall identify staff responsible for the overall operation of the incident management program, and shall train staff regarding their related roles and responsibilities.

(2) Incident management plan. Mental health providers shall develop and implement a written incident management plan, which shall include the following:

(i) the goals and objectives of the incident management program; and

(ii) the policies and procedures for the operation of the incident management program which address, at a minimum, the following:

(a) identification, documentation, reporting and investigation of incidents;

(b) review of individual incidents to identify appropriate preventive or corrective action;

(c) review of the facts, circumstances, processes, systems, and areas of risk that contributed to an incident, as well as opportunities for performance improvement;

(d) identification, review, and documentation of incident patterns and trends; and

(e) monitoring of incident management practices and developing proactive strategies for risk reduction, error prevention, and performance improvement.

(3) Monitoring. Programs shall ensure that appropriate mechanisms exist for monitoring the overall effectiveness of the incident management program.

Section 524.7. Incident reporting requirements

The following incidents are considered reportable incidents which must be reported to the Justice Center and/or the office in accordance with the provisions of section 524.8 of this Part:

(a) Allegations of abuse or neglect:

(1) physical abuse;

(2) psychological abuse;

(3) sexual abuse;

(4) deliberate inappropriate use of restraint;

(5) obstruction of reports of reportable incidents;

(6) unlawful use or administration of controlled substance;

(7) use of aversive conditioning; or

(8) neglect.

(b) Significant incidents. The following incidents are significant incidents when they occur on program premises or, with the exception of paragraph (4), when the patient was under the actual or intended supervision of a custodian when the event occurred:

(1) assault;

(2) choking;

(3) crime;

(4) falls by patients while in an inpatient or residential setting;

(5) fights;

(6) financial exploitation;

(7) fire setting;

(8) injury of unknown origin;

(9) medication errors;

(10) missing patient;

(11) inappropriate use of Restraint or Seclusion;

(12) other Incident;

(13) overdose;

(14) self abuse;

(15) severe adverse drug reaction;

(16) sexual contact between children;

(17) sexual assault;

(18) suicide attempt;

(19) verbal aggression by Patients;

(20) wrongful conduct.

(c) OMH-only reportable incidents. The following incidents are considered reportable incidents which must be reported to the office in accordance with the provisions of

section 524.10 of this Part:

(1) crimes in the community;

(2) missing subject of AOT order;

(3) suicide attempt, off-site;

(4) death of an individual receiving outpatient mental health services; or

(5) a patient of an inpatient or residential youth program, while on authorized leave or pass from the program, is the victim of human trafficking.

Section 524.8. Incident reporting procedures

Incident management programs shall include procedures for promptly reporting incidents consistent with the following:

(a) Reportable incidents identified in section 524.7(a), (b), and (c) of this Part that must be reported to the Justice Center and/or the office must be made in accordance with the following, provided, however, that nothing in this section shall be deemed to prohibit a mandated reporter from contacting or reporting to law enforcement or emergency services before or after making a report to the Vulnerable Persons' Central Register.

(1) Justice Center. Employees of mental health providers who are mandated reporters, must immediately make a report of a reportable incident to the Justice Center's Vulnerable Persons' Central Register, upon discovery of what appears to be a reportable incident.

(i) The report to the Justice Center's Vulnerable Persons' Central Register shall include the name, title, and contact information of every person known to the mandated reporter to have the same information as the mandated reporter concerning the incident.

(ii) If the reportable incident is a death for which there is any reason to believe that abuse or neglect may be involved, the mandated reporter must immediately contact the Justice Center's Vulnerable Persons' Central Register 24/7 Hotline and provide all information requested by the Justice Center, to the best of their ability.

(iii) The mandated reporter must immediately notify the director of the mental health provider, or their designee, that a report has been made.

(iv) An initial incident report in the form and format specified by the Justice Center shall be completed within 24 hours of discovery.

(v) The Justice Center has the statutory authority to investigate allegations of abuse or neglect and significant incidents. A mental health provider and its employees are required to cooperate fully with the Justice Center regarding such investigations, including but not limited to providing access at any and all times to all patients, staff, and any facility building, room or place or part thereof and to all books, records, and data pertaining to such program's patients, staff, facility or part thereof. All relevant records and reports shall be made available, upon request, to investigators at any point following the report of the incident. Patients, employees and any other persons may be interviewed in conjunction with any such investigation.

(2) Office of Mental Health. Mental health providers are responsible for immediately notifying the Office of reportable incidents within 24 hours of discovery.

(i) Such notification shall be in a form or format specified by the Office, and shall include such information as is known at the time the form is completed.

(ii) The Office has the statutory authority to investigate all incidents. A mental health provider and its employees are required to cooperate fully with the Office regarding such investigations, including but not limited to providing access at any and all times to all patients, staff, and any facility building, room or place or part thereof and to all books, records, and data pertaining to such program's patients, staff, facility or part thereof. All relevant records and reports shall be made available, upon request, to investigators at any point following the report of the incident. Patients, employees and any other persons may be interviewed in conjunction with any such investigation.

(b) If, at any point in an investigation, facts are discovered that suggest an incident should be reclassified (e.g., facts are discovered indicating a significant incident must be upgraded to abuse or neglect), all reports applicable to the revised incident type must be made.

(c) Nothing in this Part shall be deemed to supersede the obligation of providers licensed or administered by the Office to directly report crimes to the district attorney or law enforcement and the Office when it appears that a crime may have been committed against a person receiving services, pursuant to Section 31.11 of the Mental Hygiene Law.

(d) Nothing in this Part shall be deemed to preclude providers from identifying other incident types, not required to be reported and investigated pursuant to this Part, that may be investigated, monitored, and analyzed pursuant to internal quality management procedures.

(e) In cases where multiple mandated reporters have direct knowledge of the same reportable incident or have reasonable cause to suspect such incident has occurred, each mandated reporter is required to report such incident, unless they know that the report has already been made by another mandated reporter and that this person has been named in that report as a person with knowledge of such incident. Providers shall establish written protocols to ensure

reports involving multiple mandated reporters are properly made and documented.

(f) The office shall develop protocols in consultation with the Justice Center to assist providers in appropriately and therapeutically responding in circumstances where patients have a demonstrated pattern of frequently reporting allegations of abuse or neglect where there is no reasonable cause to suspect that an incident occurred.

(g) In circumstances where a patient reports an allegation of abuse or neglect to a provider which appears to be impossible or incredible, such provider shall promptly review the matter and must determine, within 24 hours of such report, whether there is reasonable cause to suspect that a reportable incident has occurred. Discovery of the incident shall be deemed to be when the provider determined that such reasonable cause exists. If it is determined that reasonable cause does not exist and a report is not made to the Justice Center, such decision shall be documented.

(h) Providers must establish a dedicated electronic mailbox to receive incident notifications in order to act on issues, including requests from the office, in a timely manner.

Section 524.9. Incident investigation, corrective action, and records maintenance

(a) Care and Safety of a Patient Involved in an incident: Directors of mental health providers or their designees must ensure that their incident management programs require any staff person who observes or is informed that a Reportable Incident of any type has occurred to immediately provide assistance and secure appropriate care for the involved patient or patients. Such Directors shall provide the Office with contact information for administrators who can be contacted by the Office at any time, on a 24 hour per day, seven day a week basis, for the purpose of ensuring that such measures have been taken.

(1) If an allegation of abuse or assault has been made, appropriate care shall include separating the alleged perpetrator from the alleged victim, in circumstances where it appears the allegation is credible and sufficient staff coverage can otherwise be maintained. In all cases, the welfare of the patient is paramount.

(2) Reasonable actions must be taken to ensure that a patient who has been harmed receives necessary treatment or care. If a patient has been injured, such actions shall include a medical examination commensurate with the acuity of the injury. The name of the examiner, the written findings of the examiner, and a copy of any other medical record associated with such examination shall be retained by the mental health provider.

(3) In addition, mental health providers shall review their activities in response to reportable incidents to ensure that corrective actions will be taken as necessary to address systems and personnel issues that may pose a continued risk to individuals in care.

(b) Documentation. Incident management programs shall include procedures for documenting

the occurrence of incidents and the results of all related examinations, investigations and reviews. Incident-related documents are confidential quality assurance documents which shall be maintained separately from the patient's clinical record. However, a description of any clinical impact which an incident may have on a patient shall be recorded in the clinical record.

(c) Investigation Process. Investigations conducted by the Office and mental health providers shall be governed by the provisions of this subdivision.

(1) All incidents shall be thoroughly investigated in a timely manner by staff competent to conduct such investigations.

(2) Investigating entity:

(i) The Justice Center has the authority to investigate allegations of abuse or neglect and significant incidents. It may delegate authority for doing so to the Office.

(ii) The Office may delegate responsibility for investigating an incident to the mental health provider.

(3) Restrictions.

(i) No one may conduct the investigation of any reportable incident in which they were directly involved, or in which their testimony has been incorporated, or in which a spouse, domestic partner, or immediate family member was directly involved.

(ii) No party in the line of supervision of staff who were directly involved in a reportable incident may conduct the investigation, provided, however, the director of the mental health provider may conduct the investigation if they are not an immediate supervisor of any staff who were directly involved in such incident.

(4) Commencing the investigation. As soon as a provider of services is made aware that an allegation of abuse or neglect has been reported to the Justice Center, or a patient death has occurred, such provider is responsible for immediately conducting any assessment or review that may be necessary, provided, however, that witness statements, interviews and interrogations are not conducted and written statements shall not be taken by anyone other than the investigating entity designated in accordance with paragraph (2) of this subdivision. If the Justice Center or the office subsequently assumes responsibility for the investigation, the provider must identify the initial investigatory steps that have been taken and supply any and all preliminary information it has obtained.

(5) Process. The investigation process shall be conducted in accordance with guidelines of the Office and shall include the following components, which must be implemented

commensurate with the type and severity of the incident:

(i) Preservation of Evidence.

(a) Where there is physical evidence of an incident, it should be preserved whenever possible, maintaining a chain of possession. For example, if a patient is injured, bloodied clothing or linens should be saved, labeled as to date, time, and location where found, and the identity of all persons who handled the item recorded, until such time as any investigation and any disciplinary action is completed. Directors of mental health providers shall be responsible for ensuring secure storage space for such evidence is available.

(b) If the incident is an allegation of physical abuse, photographs should be taken to document evidence of injury, or lack thereof.

(c) Any written documents potentially associated with the incident shall be collected and safeguarded as soon as the incident is reported or discovered, to ensure that they are not altered or lost. Such documents may include, but are not limited to, patients' charts, staff assignment logs, incident reports, and shift-to-shift communication books.

(ii) Interviewing Witnesses.

(a) Potential witnesses to an incident, which may include patients, shall be interviewed by persons qualified to conduct such interviews. Interviews should be conducted separately and as privately as possible.

(b) Each potential witness should be asked appropriate questions in an effort to gather pertinent information about the incident. Where possible, investigators should take into consideration any apparent issues which may impact an individual's manner of communication, such as culture, English proficiency, nature of disability, acuity of illness, etc. Before interviewing patients who are children, consent from the child's parent or guardian should be obtained if in the best interest of the child. Children should also be given the option of having clinical support in the room with them as long as it is not someone who may also be interviewed in the course of the investigation or asked to provide a witness statement.

(iii) Analysis of Evidence. To the extent possible, all available information pertinent to the incident shall be reviewed. Examples of such information may include, but are not limited to, photographs or videos, the alleged site/location of the incident, records and documents of the mental health provider, witness statements, records or documents from external assessments or surveys, and/or records of similar previous incidents.

(d) Final Reports.

(1) Abuse and Neglect. The results of an incident investigation shall be summarized in a written final investigative report. The purpose of such report is to describe the methods and procedures used in conducting the investigation, summarize the interviews and other evidence collected, outline the factual theories considered, explain the preliminary findings and conclusions reached (with reference to the supporting information obtained in the investigation), identify concerns, and provide recommendations with respect to substantiating or unsubstantiating the allegations.

(2) Incidents reported to the Justice Center and the Office. For all significant incidents that were accepted by the Vulnerable Persons' Central Register, providers of mental health services shall submit investigative findings to the Office, which shall submit them to the Justice Center.

(3) Incidents reported only to the Office. For those incidents which are only reported to the Office in accordance with section 524.10(b) of this Part, providers of mental health services shall submit investigative findings to the Office.

(4) Submission of reports or investigative findings:

(i) Final reports and investigative findings for reportable incidents must be submitted in the manner, form, and format specified by the Justice Center and the Office.

(ii) Abuse and Neglect. Final reports must be submitted to the Office within 45 calendar days of the Vulnerable Persons' Central Register acceptance of a report of an allegation of abuse or neglect.

(iii) Significant Incidents. Investigative findings must be submitted to the Office within 45 calendar days of acceptance by the Vulnerable Persons' Central Register of a report of a significant incident.

(iv) Death reporting. Death reports must be submitted to the Justice Center and the Office within five business days of incident or discovery of incident. A Death report shall be reopened and updated upon receipt of an autopsy report, where applicable.

(5) If the Justice Center or the Office conducts an investigation of a licensed provider of mental health services, such provider is not required to submit a final investigative report or investigative findings to the Justice Center.

(i) If the Office conducts the investigation, the Office shall submit the final report or investigative findings to the Justice Center, as required, provided, however, that the provider of mental health services shall supply information as requested by the Justice Center or the Office as may be necessary for the completion of the

final investigative report or investigative findings.

(ii) If a provider of mental health services has conducted an investigation of a significant incident delegated to it by the Office, the Office shall submit investigative findings to the Justice Center, consistent with guidance issued by the Office.

(e) Confidentiality. All documents, reports, and information obtained in the course of the investigation are confidential and shall not be used or disclosed except as authorized by federal or state laws and regulations. Such documents, records, and information shall be maintained so as to protect the privacy of patients, anyone involved in a reportable incident, or others whose names appear in the report or whose identity in the report is otherwise easy to ascertain.

Section 524.10. Additional incidents reportable to the Office of Mental Health

(a) State operated or licensed mental health providers shall immediately notify the office, in a form and format prescribed by the office, of OMH-only reportable incidents when they occur off the premises of the facility or program and when the patient was not under the intended or actual supervision of a custodian.

(b) These incidents shall not be reported to the Vulnerable Persons' Central Register, but must be reported and investigated consistent with guidelines of the office.

Section 524.11. Patient death reporting

(a) State operated or licensed mental health providers are responsible for reporting the death of a patient who was enrolled in or receiving services from the facility or program at the time of the death, or whose death was within 30 days of discharge from a mental health program.

(b) Reports of patient death must be made in accordance with the following:

(1) Justice Center Medical Review Board.

(i) The Justice Center Medical Review Board must be notified through the Justice Center's Vulnerable Persons' Central Register Death Reporting Unit, of the death of a patient of a State operated or licensed mental health provider who was enrolled in or receiving services from a Comprehensive Psychiatric Emergency Program, Inpatient, or Residential program at the time of the death, or whose death occurred within 30 days of discharge from such programs.

(ii) Such notification must be made immediately upon discovery of the death, and in no event later than 24 hours thereafter in the form and format prescribed by the Justice Center, and shall include:

(a) the name and age of the deceased;

(b) the date, time, location and circumstances of the death;

(c) to the extent known, whether or not the death:

(1) was related to an accident;

(2) may have resulted from a suicide or homicide;

(3) may have resulted from a medication overdose, or the use of controlled substance or alcohol;

(4) occurred within 72 hours of the use of restraint or seclusion; or

(5) may be an unexplained death.

(iii) The director or their designee shall submit any additional information requested by the Justice Center within five working days of such request, in the manner prescribed by the Justice Center.

(iv) In addition to the information submitted in accordance with subparagraph (iii) of this paragraph, a report of any autopsy performed on the decedent shall be submitted to the Justice Center within 60 working days of the report made to the Justice Center, provided, however, that the Justice Center may extend that timeframe for good cause shown.

(2) Coroner/medical examiner. The following shall be reported to the coroner/medical examiner:

(i) the death of a patient resulting from an apparent homicide, suicide, or unexplained or accidental cause;

(ii) the death of a patient which is unrelated to the natural course of illness or disease; or

(iii) the death of a patient which is related to the lack of treatment provided in accordance with generally accepted medical standards.

(c) Reports of patient death from an outpatient program must be made in accordance with Part 524.10.

Section 524.12. Other required notifications

In addition to the reporting requirements identified in section 524.7 of this Part, mental health providers shall have procedures to assure that the following notifications occur:

(a) Child abuse (by family or caretaker). Suspected abuse or neglect of persons under age 18 by a parent, guardian, or caretaker in a foster family boarding home, must be reported to the Statewide Central Register of Child Abuse and Maltreatment in accordance with the provisions of section 413 of the Social Services Law. Effective June 30, 2013, mandatory reporting of abuse and neglect by custodians, as defined in section 524.4 of Part, will not be accepted by the Statewide Central Register and must be made to the Vulnerable Persons' Central Register in accordance with the provisions of this Part.

(b) Notification to patients, family, or personal representatives.

(1) Upon admission patients and qualified persons shall be informed in writing of their rights to receive information pursuant to Mental Hygiene Law sections 33.23 and 33.25.

(i) When an incident affects a patient's health or safety, or a reportable incident occurs involving an allegation of abuse or neglect, wrongful conduct, missing patient, or death, the agency must provide telephone notice to a qualified person, as defined in paragraph six of subdivision (a) of section 33.16 of the Mental Hygiene Law, within 24 hours of the initial reporting of an incident.

(ii) The agency must not provide such notice to a qualified person in the following situations:

(a) if the qualified person is the alleged abuser;

(b) if there is written advice from the qualified person that they object to receiving such notification. The notice must then be provided to another qualified person if one exists; or

(c) if the person receiving services is a capable adult who objects to such notification being made.

(1) If the capable adult objects to notification of a qualified person, the capable adult must be provided the notice described in this clause.

(iii) At the qualified person's request, the following must be completed:

(a) provide the qualified person with a copy of the written incident report, provided that the names and other personally identifiable information of patients and employees are redacted unless patients and employees authorize such disclosure;

(b) meet with the qualified person to discuss the incident; and

(c) within 10 days send the qualified person a written report on the actions taken to address the incident (Actions Taken Report).

(iv) In accordance with Mental Hygiene Law 33.25, upon written request to the provider, qualified persons may obtain records and documents related to reportable incidents including the results of the investigation within 21 days of either the conclusion of the investigation or the written request, whichever is later, provided that the names and other personally identifiable information of patients and employees are redacted unless patients and employees authorize such disclosure.

(v) In accordance with Mental Hygiene Law section 33.25, incidents or allegations reported to the Justice Center, shall not be deemed to be serving a quality assurance function as defined pursuant to Social Services Law section 490(b). As such, the only information that may be redacted are names and other personally identifying information of other patients and employees unless such patients and employees authorize disclosure.

(2) The following documentation must be maintained by the provider:

(i) the telephone notice and responses received, including the identity and position of the person providing the notice, the name of the person receiving the notice, the time of the original call or attempted call, the time of subsequent attempted calls if the initial call was not successful and the time of follow up calls if the notice occurred in more than one call;

(ii) any requests for a meeting or the initial incident/occurrence report;

(iii) meetings held in response to the request, and those present;

(iv) a copy of the Actions Taken Report and any initial incident/occurrence report (with redaction) that was given to the qualified person; and

(v) advice that a particular qualified person does not want to receive notifications or that the capable adult receiving services objects to notice or objects to the provision of documents/information;

(vi) a copy of the full investigative report with identifying names of employees.

(3) Administrative appeal process--denial of requested records/documents.

(i) A qualified person denied access to the records and documents requested pursuant to this section may appeal such denial, in writing, to the Office of Mental Health’s Office of Quality Improvement.

(ii) Upon receipt of the appeal, the agency issuing the denial will be notified of the appeal and given an opportunity to submit relevant information to the Office of Quality Improvement, including the reasons for denial, within 10 business days of the receipt of such appeal. The Office of Quality Improvement may also request additional information from the qualified person as may be necessary to resolve the appeal.

(iii) Within 10 business days of the receipt of complete information, the Office of Quality Improvement will make a determination about whether the requested records and/or documents should be released. The Office of Quality Improvement will issue their determination with an explanation of the reasons for the determination to the qualified person and the agency. If so, directed by the Office of Quality Improvement, the agency must provide the requested records and/or documents to the requestor.

(iv) Note that records maintained by the agency may also be available under section 496 of the Social Services Law to other persons named in the report as defined in section 488 of the Social Services Law.

Section 524.13. Analysis, review, and monitoring of incidents

(a) Mental health providers are responsible for compiling and analyzing incident data for reportable incidents, incidents reported to the office pursuant to section 524.10 of this Part, and patient death, for the purpose of identifying possible patterns and trends and to determine the timeliness, thoroughness, and appropriateness of the provider's responses.

(1) At a minimum, incident data shall be analyzed according to incident type, patient involvement, location, date, and time, and employee involvement.

(2) Reviews shall not be considered to be complete until all relevant information, (including final investigation reports and relevant systems analyses), has been gathered, opportunities for improvement have been identified, and, if deemed necessary, plans of correction/prevention have been developed, implemented, and monitored for efficacy.

(3) For investigations of reportable incidents, correction/prevention plans must be documented in accordance with guidelines of the Office.

(b) Incident review committees. Each mental health provider shall appoint a standing incident review committee to assure that all reportable incidents, incidents reported to the office pursuant to section 524.10 of this Part, and patient death, are reviewed and monitored, that all reportable incidents that may adversely affect the care and safety of patients are appropriately addressed, and that preventive and corrective measures are identified, as appropriate.

(1) Incident review committees may be organized on a provider-wide, multi-program or program-specific basis, and may have responsibilities other than those related to

incident management.

(i) A State oversight agency may allow a facility or provider agency's incident review committee:

(a) to be shared with another facility or provider agency; or

(b) performed by another facility or provider agency on its behalf where a facility or provider agency is co-located within another organization or agency, or is part of a larger organization or agency, or has a larger "parent" or "umbrella" organization or agency.

(ii) The composition of an incident review committee must be such that a free and open exchange of information is ensured, in order to facilitate full and complete investigations. Providers shall maintain current documentation attesting that committee membership at least includes:

(a) members of the governing body of the mental health provider;

(b) persons identified by the director of such provider, including some members of the following:

(1) direct support staff, which shall mean staff who are involved in the provision of direct care services;

(2) licensed health care practitioners;

(3) service recipients; and

(4) representatives of family, consumer, or advocacy organizations.

(2) The director of the mental health provider shall not be a member of the incident review committee. For purposes of this section, "director" shall mean:

(i) the executive director of a State operated facility; or

(ii) the chief executive director of a licensed provider of mental health services, as designated by the signatory (or their successor) of the Prior Approval Review form Part A Acknowledgment submitted in accordance with Part 551 of this Title.

(3) The incident review committee shall include a licensed health care practitioner (e.g. physician, physician assistant, nurse practitioner, or registered nurse), on a regular membership or ad hoc basis. These licensed health care practitioners shall participate in review of all medically related incidents.

(4) The scheduling of incident review committee meetings shall in no way preclude the prompt and thorough review of each incident. Each incident review committee shall meet within 45 days of acceptance of the report by the Justice Center and/or the office, or sooner, should the circumstances so warrant, but no less frequently than on a quarterly basis, to allow for the timely review and closure of incidents.

(5) Incident review committees shall take an active role in assuring that:

(i) Incidents are reported, managed, investigated and documented consistent with the provisions of this Part and with the provider's policies and procedures, and written recommendations are made to the appropriate staff and/or the director of the provider of services to correct, improve or eliminate inconsistencies;

(ii) necessary and appropriate corrective, preventive, and/or disciplinary action is taken to protect persons receiving services from harm and to safeguard against the recurrence of similar incidents;

(iii) if further investigation or if additional corrective, preventive, and/or disciplinary action is necessary, appropriate written recommendations are made to the director of the provider relative to the incident;

(iv) trends in incidents, (e.g., by type, person, site, employee involvement, time, date, circumstances, etc.), are identified, and recommendations are made regarding appropriate corrective, preventive, and/or disciplinary action to the director to safeguard against and reduce such recurring situations or incidents; and

(v) the provider's reporting and review practices, including the monitoring of the implementation of approved recommendations for corrective and preventive action, are effective.

(6) Incident review committee members who may bear some responsibility for an incident shall be excluded from the committee's deliberations regarding that incident.

(7) Written minutes of all meetings shall be maintained.

(i) Minutes shall indicate when review of a particular incident has been completed. Review shall be deemed complete when all relevant information, including the final investigative report, has been gathered, opportunities for improvement have been identified, and plans of correction/prevention have been developed, implemented, and monitored.

(ii) Minutes are to be filed and otherwise maintained in a manner that ensures confidentiality.

(8) Reports based on the minutes shall be developed and submitted to the director of the

mental health provider, as determined necessary by the committee. Such reports shall include a summary of the Committee's discussions, findings and recommendations, as well as follow-up actions taken to assure that all recommended preventive and/or corrective measure(s) are implemented.

(9) All members of the Incident Review Committee must be trained in relevant confidentiality laws and regulations.

Section 524.14. Special investigations

(a) For the following types of incidents, if the Justice Center is not conducting an investigation, the mental health provider shall ensure that a special investigation is completed.

(1) inpatient homicides;

(2) inpatient suicides;

(3) all inpatient deaths except natural deaths;

(4) homicide and suicide attempts by inpatients;

(5) allegations of abuse and neglect;

(6) inpatient assaults resulting in serious injury to any person, including sexual assaults;

(7) missing patients of inpatient programs;

(8) wrongful conduct;

(9) inappropriate use of restraint or seclusion; and

(10) financial exploitation.

(b) Special investigation reports shall be conducted in a manner consistent with section 524.9 of this Part, and shall be submitted to the Office in a form and format designated by the Office.

Section 524.15. Employee code of conduct and training

(a) Directors of mental health providers are responsible for ensuring that each employee receives a copy of the Code of Conduct developed by the Justice Center pursuant to Section 554 of the Executive Law.

(1) Persons hired by the mental health provider on or after June 30, 2013, shall be provided with such Code upon initial hiring.

(2) Written confirmation of receipt of the Code of Conduct shall be obtained for each employee and maintained in his or her personnel file, upon initial distribution and at least annually thereafter. Such confirmation shall indicate that the employee has read and understands the Code provisions.

(3) Distribution of the Code can be manual or electronic, provided there is a reliable mechanism to confirm that the Code has been received, and signed, by each employee, which is easily accessible to monitor compliance with the provisions of this subdivision.

(b) Training.

(1) Directors of mental health providers shall ensure that all employees who are mandated reporters shall receive training in the following areas upon hire and at least on an annual basis:

(i) abuse prevention, identification, reporting, and processing of allegations of abuse and neglect;

(ii) laws, regulations and policies/procedures governing protection from allegations of abuse and neglect; and

(iii) incident reporting and processing.

(2) Directors of mental health providers shall ensure that there is a mechanism for monitoring the type, frequency and amount of such training employees received, and that:

(i) the records are current; and

(ii) there is documentation establishing that employees have received the specified training.

Section 524.16. Penalties for violation

Upon a determination that a mental health provider is in violation of this Part, the Commissioner may impose a fine not to exceed $1,000 per day or $15,000 per violation in accordance with section 31.16 of the Mental Hygiene Law and Part 503 of this Title, and/or may suspend, revoke, or limit an operating certificate or take any other appropriate action, in accordance with applicable law and regulations.