WESTMOUNT HEALTH FACILITY AND COUNTRYSIDE ADULT HOME
HEALTH SERVICES COMMITTEE MEETING
FRIDAY, MARCH 28, 2008
9:30 A.M.
MUNICIPAL BUILDING BOARD ROOM

WESTMOUNT HEALTH FACILITY

1.) AIR HANDLERS UPDATE.

2.) REQUEST TO TRANSFER FUNDS OUT OF CODE. HCRA RECRUITMENT AND RETENTION GRANT FUNDS UTILIZED.

- DIETARY ADVERTISING
- MAINTENANCE SALARIES
- NURSING ADMINISTRATION SALARIES – ADON
- NURSING SUPERVISOR AND RN SALARIES

3.) REQUEST TO TRANSFER FUNDS OUT OF CODE FROM MAINTENANCE SUPPLIES TO MAINTENANCE FURNITURE/EQUIPMENT.

4.) REQUEST TO AMEND MEMORANDUM OF UNDERSTANDING BETWEEN WARREN COUNTY DEPT. OF SOCIAL SERVICES AND WESTMOUNT.

5.) REQUEST RESOLUTION TO ATTEND CONFERENCES.

6.) 2007 BUDGET EXPENSE REPORT.

7.) 2008 DEPT. OF HEALTH FACILITY SURVEY Feb. 12th, 13th, 14th and 19th. PLAN OF CORRECTION ACCEPTED 03/21/08.

8.) REQUEST TO FILL VACANT POSITIONS.

9.) STAFFING LEVELS.

10.) OVERTIME REPORT.

COUNTRYSIDE

1.) 2007 BUDGET REVIEW

2.) REQUEST FOR RESOLUTION TO PAY SIEMENS FOR EMERGENCY REPAIR TO OUR PEERLESS BOILER.

RESOLUTION REQUEST FORM NO. 7

*Request to Amend County Budget**

If this is the result of a grant award, also complete and submit Form No. 5 or 6

DEPARTMENT NAME: WESTMOUNT HEALTH FACILITY

DATE: March 28, 2008

(a) Purpose of Amendment: To Amend 2008 Dietary Advertising Appropriations with HCRA Grant Funds.

(b) Appropriation Code (with title), Object Code (with title) and Amount: EF.82100.9101 436 Westmount, Dietary service, Other Direct Costs Advertising Fees $ 260.00 dollars

(c) Revenue Code (with title), and Amount: EF.901002 3489 Westmount, HCRA Grant - Recruitment Retention, Health, Other $ 260.00

PURCHASE ORDER

WESTMOUNT HEALTH FACILITY

42 Gurney Lane

Queensbury, NY 12804

№ 35332

14760

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ne &
ress

TO: POST STAR
ADVERTISING DEPT
PO BOX 561
Glens Falls NY 12801

SHIP TO:

Check # _____

Date Paid _____

ADVERTISING -

DATE	DATE REQUIRED	TERMS	F.O.B.	SHIP VIA	DEPT. OF REQ. NO.	FOR COUNTY USE	FOR DEPARTMENT USE
3-14-08	ASAP				DIETARY	☐	☐

QUANTITY	DESCRIPTION	PRICE	AMOUNT
	HELP WANTED IN-COLUMN AD		
	to run for 3 Days		
	Mon - MARCH 17		
	Tues March 18		256.75
	Wed March 19		
	★ FOOD SERVICE HELPER ★		
	PER DIEM		
	Evenings & Weekends		
	Experience Preferred		
	$10.82 Hour		
	APPLY IN PERSON AT:		
	WESTMOUNT Health Facility		
	42 GURNEY LANE		
	QUEENSBURY NY M-F 8AM-4PM		
	PRIOR APPLICANTS NEED NOT APPLY		

FOR COUNTY USE ONLY - PLEASE DO NOT WRITE BELOW THIS LINE

P.O. NO. OR ENC. NO.	FUND/ORG.	ACCOUNT	AMT. LIQUIDATED	DEPT.	ARMS	AMOUNT
EF	.82100	.9101		0240	436	

REC'D BY _____

DATE _____

APPROVED BY Barbara Tassart/kar

IMPORTANT
IN ALL CORRESPONDENCE, INVOICES AND PACKAGES, NOTIFY US IMMEDIATELY IF UNABLE TO SHIP ORDER COMPLETE BY DATE SPECIFIED

RESOLUTION REQUEST FORM NO. 7

*Request to Amend County Budget**

If this is the result of a grant award, also complete and submit Form No. 5 or 6

DEPARTMENT NAME: WESTMOUNT HEALTH FACILITY

DATE: March 28, 2008

(a) Purpose of Amendment: To Amend 2008 Maintenance Salaries Approprations with HCRA Recuitment and Retention Gant Funds

(b) Appropriation Code (with title), Object Code (with title) and Amount: Westmount. Plant Operation and Maintenance, FSH HK LL Maintenance Salaries - Regular EF.82200.700 110 $13,422.00

(c) Revenue Code (with title), and Amount: HCRA Recuitment and Retention Grant EF.901002 3489 $13,422.00

RESOLUTION REQUEST FORM NO. 7

*Request to Amend County Budget**

If this is the result of a grant award, also complete and submit Form No. 5 or 6

DEPARTMENT NAME: WESTMOUNT HEALTH FACILITY

DATE: March 28, 2008

(a) Purpose of Amendment: To Amend 2008 Nursing Administration Salaries Approprations for ADON with HCRA Recuitment and Retention Gant Funds

(b) Appropriation Code (with title), Object Code (with title) and Amount: Westmount. Nursing Administration. Management and Supervison Salaries - Regular EF.60100.100 110 $1,032.00

(c) Revenue Code (with title), and Amount: HCRA Recuitment and Retention Grant EF.901002 3489 $1,032.00

RESOLUTION REQUEST FORM NO. 7

*Request to Amend County Budget**

If this is the result of a grant award, also complete and submit Form No. 5 or 6

DEPARTMENT NAME: WESTMOUNT HEALTH FACILITY

DATE: March 28, 2008

(a) Purpose of Amendment: To Amend 2008 Nursing Supervisor & RN Supervisor Salary Approprations with HCRA Recuitment and Retention Gant Funds

(b) Appropriation Code (with title), Object Code (with title) and Amount: Westmount. Nursing-Nurses' Stations. Management and Supervision Salaries-Regular EF.60200.100 110 $5,160.00

(c) Revenue Code (with title), and Amount: HCRA Recuitment and Retention Grant EF.901002 3489 $5,160.00

RESOLUTION REQUEST FORM NO. 7

*Request to Amend County Budget**

If this is the result of a grant award, also complete and submit Form No. 5 or 6

DEPARTMENT NAME: WESTMOUNT HEALTH FACILITY

DATE: March 28, 2008

(a) Purpose of Amendment: To Amend 2008 Nursing Salaries for RN Approprations with HCRA Recuitment and Retention Gant Funds

(b) Appropriation Code (with title), Object Code (with title) and Amount: Westmount. Nursing-Nurses' Stations. Registered Nurses Wages Salaries-Regular EF.60200.300 110 $15,021.00

(c) Revenue Code (with title), and Amount: HCRA Recuitment and Retention Grant EF.901002 3489 $15,021.00

REQUEST FOR TRANSFER OF FUNDS

TO: JOAN SADY, CLERK, WARREN COUNTY BOARD OF SUPERVISORS

FROM: WESTMOUNT HEALTH FACILITY

SIGNED: _____

DATE: MARCH 28, 2008

FROM CODE	TITLE	TO CODE	TITLE	AMOUNT
EF.82200.5906 410	Westmount Plant & Operation Maintenance Supplies	EF.82200.5802 210	Westmount Plant & Operation Maintenance Furniture Equipment	$90.00

PLEASE STATE REASON FOR TRANSFERS REQUESTED:

~~LACK OF FUNDS.~~

CONTINGENT FUND TRANSFER REQUESTS

FROM CODE	TITLE	TO CODE	TITLE	AMOUNT

PLEASE STATE REASON FOR TRANSFER REQUEST:

PLEASE FILE ORIGINAL REQUEST WITH CLERK OF THE BOARD AND

RETAIN COPY FOR YOUR RECORDS.

PURCHASE ORDER

WESTMOUNT HEALTH FACILITY

42 Gurney Lane

Queensbury, NY 12804

№ 35313

12066

Vendor Name & Address — TO: Lowes — SHIP TO:

Check # _____

Date Paid _____

DATE	DATE REQUIRED	TERMS	F.O.B.	SHIP VIA	DEPT. OF REQ. NO.	P.O. over $500	P.O. under $500
3/10/08					Maint.	☐	☐

QUANTITY	DESCRIPTION	PRICE	AMOUNT
2	WALL CAB. UNITS	44.87	89.74
1	WHITE SINK KIT.	16.97	16.97
2	2x3x8	1.57	3.14
		TOT.	109.85

FOR COUNTY USE ONLY - PLEASE DO NOT WRITE BELOW THIS LINE

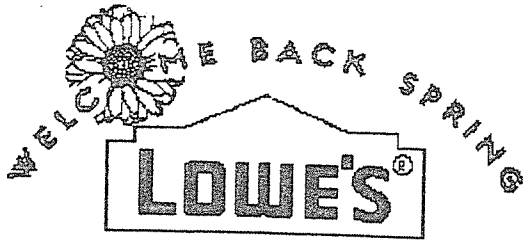
P.O. NO. OR ENC. NO.	FUND/ORG.	ACCOUNT	AMT. LIQUIDATED	DEPT.	ARMS	AMOUNT
EF	.82200	.5906	20.11 ~~109 85~~	0245	410	20.11 ~~109 85~~
EF	.82200	.5802	89 74	0245	210	89 74

REC'D BY _____

DATE 3/10/08 APPROVED BY Barbara Tassarotti

IMPORTANT

IN ALL CORRESPONDENCE, INVOICES AND PACKAGES, NOTIFY US IMMEDIATELY IF UNABLE TO SHIP ORDER COMPLETE BY DATE SPECIFIED



LOWE'S HOME CENTERS, INC.
251 QUAKER RD.
QUEENSBURY, NY 12804
(518)798-9050
-SALE-

SALES #: S0641LJ1 70758 03-10-08
TE#: 064100422 westmount health facility

97463 BLACK & DECKER WALL & BAS	89.74
2 @ 44.87	
99820 HOLE SAW SET 7 PC 71-120L	16.97
1030 2X3X96" MULTI-PURPOSE	3.14
2 @ 1.57	
SUBTOTAL:	109.85
TAX:	0.00
INVOICE 06994 TOTAL:	109.85
BALANCE DUE:	109.85
LAR:	109.85

LAR XXXXXXXXXXX2988 000980
ACCOUNT NAME:
WESTMOUNT HEALTH FACILITY
AUTH BUYER: BESSAW ARTHUR

AMOUNT: 109.85
ACCOUNT WILL BE BILLED UPON MERCHANDISE RECEIPT OR NO LATER THAN 60 DAYS FROM TRANSACTION DATE FOR STOCK MERCHANDISE AND NO LATER THAN 90 DAYS FROM TRANSACTION DATE FOR SOS OR DIRECT DELIVERY MERCHANDISE.

0641 TERMINAL: 06 03/10/08 14:00:40

OF ITEMS PURCHASED: 5

RESOLUTION REQUEST FORM NO. 20

MISCELLANEOUS

**Please List All Other Requests Not Covered by Previous Resolution Request Forms Here.*
Please attach any backup information available and be as detailed as possible.

DEPARTMENT NAME: WESTMOUNT HEALTH FACILITY

DATE: March 28, 2008

(a) Purpose of Request: Amend Memorandum Of Understanding between Warren County Department of Social Services and Westmount Health Facility.

(b) Details: To include the authorization of all replacement Linen Inventory costs for Residential Hall to be the responsibilty of Warren County Department of Social Services.

(c) Previous Resolution Number: Resolution No. 46 of 2005

Warren County Board of Supervisors

RESOLUTION NO. 46 OF 2005

Resolution introduced by Supervisors Tessier, O'Connor, Sheehan, Bentley, Kenny, F. Thomas and Barody

AUTHORIZING A MEMORANDUM OF UNDERSTANDING BETWEEN WARREN COUNTY DEPARTMENT OF SOCIAL SERVICES AND WESTMOUNT HEALTH FACILITY FOR LINEN AND LAUNDERING SERVICES AT RESIDENTIAL HALL

RESOLVED, that the Warren County Board of Supervisors authorize a Memorandum of Understanding between the Warren County Department of Social Services and Westmount Health Facility for linen and laundering services at Residential Hall, and, be it further

RESOLVED, that the Commissioner of the Department of Social Services be and hereby is, authorized to execute said Memorandum of Understanding in the form approved by the County Attorney.

SCHEDULE "A"

AUTHORIZATION TO ATTEND MEETING OR CONVENTION

Check one:

☒ In-State (needs Supervisory Committee authorization)

☐ Out-Of State (needs Board resolution)

The Westmount Health Facility (Supervisory Committee) hereby authorizes BARBARA TAGGART (Employee Name)

to attend NYAHSA SPRING TRAINING INSTITUTE AND EXHIBITION (Name of meeting or organization)

at THE SARATOGA HILTON HOTEL & CONFERENCE CENTER: SARATOGA SPRINGS, NY (Address)

on 05/19-22/08 (Dates). Mode of transportation to be used WESTMOUNT COUNTY VEHICLE (County Vehicle or Mass Transportation)

If the mode of transportation is not a county vehicle or mass transportation, please explain:

_____

Proper documentation must be attached when submitting for approval.

(Please check documents attached)

☒ Notice of meeting or convention including cost.

For Overnight Travel

☐ Room rate $ _____ GSA* Rate $ _____

☐ Meal costs - GSA*per diem rate $ _____

*www.gsa.gov

Date: 03/28/08 _____ Department Head Signature

Date: 03/28/08 _____ Committee Chairman Signature

Please refer to the Warren County Travel Policy and County Vehicle Use Regulations for general policy guidelines.

****

Please check to request a fleet vehicle.

☐ **REQUEST FOR USE OF FLEET VEHICLE**

****

Filing Instructions:

1. Original with voucher to Auditor.
2. Copy to Frank Morehouse if fleet vehicle is needed.
3. Copy to Clerk of the Board with Resolution Request form if out-of-state travel.
4. Copy to Purchasing with Purchase Order, if required.
5. Copy to Commissioner of Administrative and Fiscal Services if credit card will be used.

SCHEDULE "A"

AUTHORIZATION TO ATTEND MEETING OR CONVENTION

Check one:

☒ In-State (needs Supervisory Committee authorization)

☐ Out-Of State (needs Board resolution)

The Westmount Health Facility (Supervisory Committee) hereby authorizes Sandra Smith (Employee Name)

to attend Medicare Management and the Skilled Nursing Facility seminare (Name of meeting or organization)

at Holiday Inn Wolf Road Albany, New York (Address)

on 5/13/2008 (Dates). Mode of transportation to be used Westmount Health County Vehicle (County Vehicle or Mass Transportation)

If the mode of transportation is **not** a county vehicle or mass transportation, please explain:

_____

Proper documentation must be attached when submitting for approval.

(Please check documents attached)

☒ Notice of meeting or convention including cost.

For Overnight Travel

☐ Room rate $ _____ GSA* Rate $ _____

☐ Meal costs - GSA*per diem rate $ _____

*www.gsa.gov

Date: March 28, 2008 _____ Department Head Signature

Date: March 28, 2008 _____ Committee Chairman Signature

Please refer to the Warren County Travel Policy and County Vehicle Use Regulations for general policy guidelines.

****

Please check to request a fleet vehicle.

☐ **REQUEST FOR USE OF FLEET VEHICLE**

****

Filing Instructions:

1. Original with voucher to Auditor.
2. Copy to Frank Morehouse if fleet vehicle is needed.
3. Copy to Clerk of the Board with Resolution Request form if out-of-state travel.
4. Copy to Purchasing with Purchase Order, if required.
5. Copy to Commissioner of Administrative and Fiscal Services if credit card will be used.

PURCHASE ORDER

WESTMOUNT HEALTH FACILITY

№ 35357

42 Gurney Lane

Queensbury, NY 12804

15246

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ne &
lress

TO: Foundation For Quality Care

SHIP TO:

Check # _____

Date Paid _____

DATE	DATE REQUIRED	TERMS	F.O.B.	SHIP VIA	DEPT. OF REQ. NO.	PGB OWN USE	PGB RESALE
5/13/08					FISCAL	☐	☐

QUANTITY	DESCRIPTION	PRICE	AMOUNT
	Seminar: "Medicare Management & the Skilled Nursing Facility"		
	May 13, 2008		175.00
	Albany		
	Sandy Smith		

FOR COUNTY USE ONLY - PLEASE DO NOT WRITE BELOW THIS LINE

P.O. NO. OR ENC. NO.	FUND/ORG.	ACCOUNT	AMT. LIQUIDATED	DEPT.	ARMS	AMOUNT
EF	83110	8800	175 00	0265	444	175 00

IMPORTANT
ON ALL CORRESPONDENCE, INVOICES AND PACKAGES, NOTIFY US IMMEDIATELY IF UNABLE TO SHIP ORDER COMPLETE BY DATE SPECIFIED

REC'D BY _____

DATE _____

APPROVED BY Sandy Smith

REGISTRATION FORM – "Medicare Management and the Skilled Nursing Facility"

SANDY SMITH
Name of Applicant

Admin. License#

HEALTH FACILITY RECORDS SPECIALIST
Title of Applicant

WESTMOUNT HEALTH FACILITY
Facility

42 GURNEY LANE
Facility Address

QUEENSBURY — NY — 12804
City — State — Zip Code

518-761-6540 ext 3779
Work Telephone

518-761-6590
Work Fax

smithhs@co.warren.ny.us
E-mail Address

If registering more than one individual, please make copies of this form.

Seminar Fees: Price includes handouts, refreshments and lunch.

NYSHFA Members: $145.00 1st registrant, $135.00 for each additional registrant from the same facility.

Non-Members: $175.00 1st registrant, $165.00 for each additional registrant from the same facility.

Special Meal Requests: _____ Kosher (If not specified, a deli lunch will be ordered for you.)

Please check if you are disabled and/or need special services: ____, services required: _____

Date & Location: (Please Check)

✓ May 13, 2008	____ May 28, 2008	____ May 29, 2008
Holiday Inn Wolf Road	Marriott Hotel	LaGuardia Marriott
Albany, NY	Melville, NY	East Elmhurst, NY

Payment Method: ☑ Check (Please make check payable to Foundation for Quality Care) ☐ Discover ☐ Visa ☐ MasterCard ☐ American Express

Credit Card # — Exp. Date

Name on Card (Exactly as appears on card)

Credit Card Billing Address

Cardholder Signature

I authorize NYSHFA to use the above MasterCard, Visa, Discover, or Amex to charge applicable registration fees. I also understand that registration fees of those who cancel the day of the program or fail to attend are forfeited. Substitutions are permitted and encouraged.

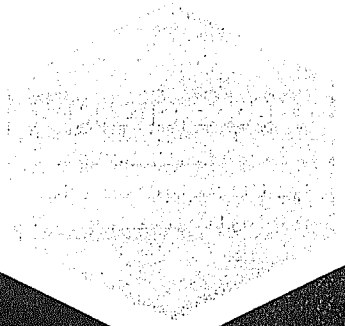
NOTE: If you have faxed in your registration, please make sure you mail the original with your payment.

Mail To
Foundation for Quality Care
33 Elk Street, Suite 300
Albany, NY 12207

Contact Information
Phone: (518) 462-4800 ext. 22
Fax: (518) 462-4370
Email: sobrien@nyshfa.org

Seminar Announcement

"Medicare Management and the Skilled Nursing Facility"



MAY 28, 2008
MELVILLE
MARRIOTT HOTEL
MELVILLE, NY

MAY 29, 2008
EAST ELMHURST
LAGUARDIA MARRIOTT
EAST ELMHURST, NY

Presented by:

Sharon Donaghue, RN—Vice President Clinical Reimbursement, Care One and Healthbridge Management

&

Patty Whitten—Director of Clinical Reimbursement, Care One and Healthbridge Management

NEW YORK STATE NYSHFA HEALTH FACILITIES ASSOCIATION, INC

5.0 CEU's for LNHA

Foundation for Quality Care

SEMINAR OVERVIEW

Knowing the "right questions to ask" is the key to overseeing any system. The *American Association of Clinical Reimbursement Specialists* have designed this program to assist Administrators, Financial Officers, Directors of Nursing, Rehabilitation Coordinators and MDS/Medicare Nurses to do just that!

Through years of experience, our speakers will share their knowledge of Medicare Parts A and B, the PPS system, the 53 RUGS model, appeals rights and consolidated billing. They will also discuss the critical components of the MDS and the ARD and how to successfully implement PPS/Medicare meetings by defining each team member's roles and responsibilities. They will also share tips on how to review the facility's billing processes for accuracy by "knowing the right questions to ask."

Objectives:

- **Implementing a successful "Medicare Meeting" to get the results you want!**
- Understand Medicare coverage and the system for monitoring requirements
- Identify eligibility, entitlement and spell of illness/benefit period
- Services covered under Medicare part A and B
- Understanding the 53 RUG Model, Case Mix verses Hierarchy
- Non-Coverage letters and appeal rights
- Consolidated Billing
- Medicare Medical Review Process
- Critical Components of the RAI
- Utilization Review
- Billing compliance

SCHEDULE:

8:00 am—9:00 am—Registration
9:00 am—Noon—Education
Noon—1:00 pm—Lunch
1:00 pm—3:00 pm—Education
3:00 pm—Adjourn

HOTEL INFORMATION

May 13, 2008	**May 28, 2008**	**May 29, 2008**
Holiday Inn Wolf Road	Marriott Hotel	LaGuardia Marriott
205 Wolf Rd.	1350 Old Walt Whitman Rd. (LIE Exit 44)	102-05 Ditmars Blvd.
Albany, NY	Melville, NY	East Elmhurst, NY
(518) 458-7250	(631) 423-1600	(718) 565-8900

PRESENTERS

Sharon Donaghue, RN—*VP Clinical Reimbursement, Care One and Healthbrige Management*
Sharon has twenty years of experience in professional nursing specializing in the clinical and financial management of subacute and long term patients. She has extensive knowledge and experience with the RAI process including teaching, program development and indepth auditing related to accuracy of information for billing purposes. Auditing Medicare and Medicaid claims for validity by review of supporting medical record documentation is an additional area of her expertise. Sharon has served in many roles including Nurse Manger, Medicare Nurse Specialist, Case Manager and Corporate Compliance Director. She was credentialed by the Office of the Inspector General for MDS auditing for a Corporate Integrity Agreement with a previous employer.

In her current role as Vice President of Clinical Reimbursement, she supports five Regional Directors of Clinical Reimbursement including an additional staff of eight regional consultants. In this role she is responsible for education and training, policy development, reviewing CMS guidelines, and implementation of systems to maintain compliance with state and federal guidelines.

Patty Whitten —*Director of Clinical Reimbursement, Care One and Healthbrige Management*
Over thirty-five years of nursing experience with the last twelve years in the reimbursement field. She has worked as a Healthcare Consultant for Medicare Claims Administration with a Fiscal Intermediary, providing analysis for appropriateness of clinical protocols in medical claim review and has conducted onsite audits for potential fraud and abuse of the Medicare program.

Patty has worked in the private Long-Term Care industry for the last ten years. She is currently the Regional Director of Clinical Reimbursement for a Long-Term Care company and is responsible for Medicare compliance and maximization of Medicare reimbursement for nine SNF/rehabilitation facilities.

GENERAL INFORMATION

Registration: Registration is required.

Registration Fees:

NYSHFA Members
$145.00 1st registrant, $135.00 for each additional registrant from the **same** facility.

Non-Members
$175.00 1st registrant, $165.00 for each additional registrant from the **same** facility.

Confirmations: Will be emailed to all paid registrants.

Questions: Please call Sharon O'Brien at (518) 462-4800 ext. 22 or email to sobrien@nyshfa.org.

WARREN COUNTY

Expense Budget Performance Report

Through Date: 12/31/2007

Account Number		Adopted Budget	Budget Amendments	Amended Budget	Current Month Transactions	YTD Encumbrances	YTD Transactions	Budget Less YTD Transactions	% Used	Prior Year Total
470	Contract	0.00	285,986.00	285,986.00	37,108.05	0.00	231,941.36	54,044.64	81%	0.00
610	Principal-Indebtedness	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
710	Interest-Indebtedness	0.00	135,230.00	135,230.00	9,690.83	0.00	130,155.25	5,074.75	96%	0.00
810	Retirement	0.00	317,499.00	317,499.00	193,618.10	0.00	263,832.85	53,666.15	83%	0.00
830	Social Security	0.00	206,200.00	206,200.00	35,941.91	0.00	199,159.42	7,040.58	97%	0.00
831	Medicare Contribution	0.00	49,707.00	49,707.00	8,405.74	0.00	46,576.86	3,130.14	94%	0.00
840	Workmen's Compensation	0.00	144,822.00	144,822.00	0.00	0.00	144,816.34	5.66	100%	0.00
850	Unemployment Insurance	0.00	7,000.00	7,000.00	3,860.30	0.00	6,429.30	570.70	92%	0.00
855	Disability	0.00	15,247.00	15,247.00	5,590.08	0.00	6,501.37	8,745.63	43%	0.00
860	Hospitalization	0.00	803,240.00	803,240.00	0.00	0.00	786,819.25	16,420.75	98%	0.00
865	Dental Insurance	0.00	16,903.00	16,903.00	0.00	0.00	14,876.00	2,027.00	88%	0.00
910	Interfund Transfers	0.00	37,500.00	37,500.00	(37,500.00)	0.00	0.00	37,500.00	0%	0.00
Fund Total: Westmount		$0.00	$6,869,978.00	$6,869,978.00	$1,022,669.04	$0.00	$6,694,288.55	$175,689.45	97%	$0.00
Grand Total:		$0.00	$6,869,978.00	$6,869,978.00	$1,022,669.04	$0.00	$6,694,288.55	$175,689.45	97%	$0.00

Fund

WARREN COUNTY

Expense Budget Performance Report

Through Date: 12/31/2007

Account Number		Adopted Budget	Budget Amendments	Amended Budget	Current Month Transactions	YTD Encumbrances	YTD Transactions	Budget Less YTD Transactions	% Used	Prior Year Total
Fund: EF - Westmount										
110	Salaries - Regular	0.00	2,951,022.00	2,951,022.00	295,681.43	0.00	3,054,387.79	(103,365.79)	104%	0.00
120	Salaries - Overtime	0.00	111,741.00	111,741.00	16,573.98	0.00	188,430.92	(76,689.92)	169%	0.00
130	Salaries - Part Time	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
140	Salaries - Sick Leave Incentive	0.00	7,200.00	7,200.00	7,000.00	0.00	7,000.00	200.00	97%	0.00
210	Furniture/Furnishings	0.00	2,095.00	2,095.00	(1,707.65)	0.00	292.01	1,802.99	14%	0.00
220	Office Equipment	0.00	10,832.00	10,832.00	(553.76)	0.00	137.23	10,694.77	1%	0.00
230	Automotive Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
250	Technical Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
260	Other Equipment	0.00	18,878.00	18,878.00	(17,978.56)	0.00	0.00	18,878.00	0%	0.00
270	Lawn & Landscaping	0.00	350.00	350.00	(349.00)	0.00	0.00	350.00	0%	0.00
320	Depreciation	0.00	325,000.00	325,000.00	94,881.00	0.00	327,714.00	(2,714.00)	101%	0.00
410	Supplies	0.00	111,433.00	111,433.00	6,710.48	0.00	103,242.46	8,190.54	93%	0.00
413	Repair & Maint.-Bldg/Property	0.00	16,174.00	16,174.00	(2,486.21)	0.00	7,263.52	8,910.48	45%	0.00
414	Gas-Natural	0.00	207,262.00	207,262.00	30,837.89	0.00	162,443.43	44,818.57	78%	0.00
415	Electricity	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
416	Oil & Gas-Heating	0.00	12,500.00	12,500.00	623.55	0.00	7,634.61	4,865.39	61%	0.00
417	Water/Sewer/Taxes	0.00	11,500.00	11,500.00	0.00	0.00	9,282.17	2,217.83	81%	0.00
418	Ins-General Liability	0.00	32,558.00	32,558.00	0.00	0.00	31,171.48	1,386.52	96%	0.00
421	Equipment Rental	0.00	28,875.00	28,875.00	5,900.02	0.00	27,913.08	961.92	97%	0.00
422	Repair/Maint-Equipment	0.00	19,566.00	19,566.00	818.62	0.00	16,090.26	3,475.74	82%	0.00
423	Telephone	0.00	4,960.00	4,960.00	487.85	0.00	4,425.41	534.59	89%	0.00
424	Postage	0.00	1,710.00	1,710.00	200.29	0.00	1,390.40	319.60	81%	0.00
425	Reproduction Expenses	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
426	Subscriptions	0.00	2,877.00	2,877.00	0.00	0.00	2,186.86	690.14	76%	0.00
427	Memberships & Dues	0.00	7,151.00	7,151.00	0.00	0.00	6,360.38	790.62	89%	0.00
428	Data Processing & Internet Fees	0.00	425.00	425.00	0.00	0.00	425.00	0.00	100%	0.00
435	Medical Fees	0.00	134,990.00	134,990.00	12,019.91	0.00	84,724.27	50,265.73	63%	0.00
436	Advertising Fees	0.00	5,283.00	5,283.00	0.00	0.00	4,701.56	581.44	89%	0.00
437	Consulting Fees	0.00	85,095.00	85,095.00	9,343.55	0.00	81,673.58	3,421.42	96%	0.00
439	Misc Fees & Expenses	0.00	2,077.00	2,077.00	461.75	0.00	1,371.75	705.25	66%	0.00
440	Legal/Transcript Fees	0.00	46.00	46.00	0.00	0.00	0.00	46.00	0%	0.00
441	Auto-Supplies & Repair	0.00	4,000.00	4,000.00	10.00	0.00	1,722.23	2,277.77	43%	0.00
442	Automotive - Gas & Oil	0.00	4,100.00	4,100.00	769.96	0.00	4,090.78	9.22	100%	0.00
444	Travel/Education/Conference	0.00	7,735.00	7,735.00	82.55	0.00	6,516.71	1,218.29	84%	0.00
445	Foods	0.00	200,767.00	200,767.00	20,528.26	0.00	190,295.34	10,471.66	95%	0.00
453	Uniforms & Clothing	0.00	400.00	400.00	0.00	0.00	399.85	0.15	100%	0.00
469	Other Payments/Contributions	0.00	522,042.00	522,042.00	286,098.12	0.00	529,893.47	(7,851.47)	102%	0.00

Fund

WARREN COUNTY

Revenue Budget Performance Report

Through Date: 12/31/2007

Account Number		Adopted Budget	Budget Amendments	Amended Budget	Current Month Transactions	YTD Encumbrances	YTD Transactions	Budget Less YTD Transactions	% Rec'd	Prior Year Total
Fund: EF - Westmount										
1650	Public Nursing Home Income	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
2150	Hook Up Fees	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
2230	Co-Generation Reimbursement	0.00	114,000.00	114,000.00	0.00	0.00	0.00	114,000.00	0%	0.00
2401	Interest & Earnings	0.00	13,000.00	13,000.00	3,621.33	0.00	19,080.91	(6,080.91)	147%	0.00
2660	Sale of Real Property	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
2680	Insurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
2701	Refund of Prior Year Expense	0.00	0.00	0.00	0.00	0.00	2,444.37	(2,444.37)	+++	0.00
2705	Gifts & Donations	0.00	220,000.00	220,000.00	242,289.16	0.00	242,289.16	(22,289.16)	110%	0.00
2770	Other Unclassified Revenue	0.00	500.00	500.00	0.00	0.00	0.00	500.00	0%	0.00
2771	Provision for Bad Debts	0.00	0.00	0.00	(3,922.00)	0.00	(3,922.00)	3,922.00	+++	0.00
3020	Private Pay Revenue	0.00	795,250.00	795,250.00	109,594.32	0.00	915,059.97	(119,809.97)	115%	0.00
3021	Physician Billing	0.00	27,000.00	27,000.00	8,853.87	0.00	25,378.56	1,621.44	94%	0.00
3022	Medicare Revenue	0.00	305,800.00	305,800.00	10,032.10	0.00	248,481.72	57,318.28	81%	0.00
3023	Medicaid Revenue	0.00	3,511,752.00	3,511,752.00	276,396.93	0.00	3,421,355.65	90,396.35	97%	0.00
3024	Patients Participation	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
3026	Daily Rate	0.00	30,000.00	30,000.00	10,568.60	0.00	30,264.56	(264.56)	101%	0.00
3027	Hospice Revenue	0.00	2,700.00	2,700.00	0.00	0.00	7,870.50	(5,170.50)	292%	0.00
3036	Public Facility Grant	0.00	104,000.00	104,000.00	0.00	0.00	83,019.00	20,981.00	80%	0.00
3037	V. A. Revenue	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
3489	Health, Other	0.00	62,953.00	62,953.00	(28,654.24)	0.00	47,693.26	15,259.74	76%	0.00
4601	Medical Assistance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
5010	Other Operating Income	0.00	200.00	200.00	0.00	0.00	207.40	(7.40)	104%	0.00
5031	Interfund Transfers	0.00	1,230,823.00	1,230,823.00	0.00	0.00	1,230,823.00	0.00	100%	0.00
5095	Vending Machine Comm	0.00	1,700.00	1,700.00	108.45	0.00	1,351.21	348.79	79%	0.00
5175	Refunds and Rebates	0.00	300.00	300.00	0.00	0.00	298.57	1.43	100%	0.00
5271	Pharmacy Income Priv. Pay	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
Fund Total: Westmount		$0.00	$6,419,978.00	$6,419,978.00	$628,888.52	$0.00	$6,271,695.84	$148,282.16	98%	$0.00
Grand Total:		$0.00	$6,419,978.00	$6,419,978.00	$628,888.52	$0.00	$6,271,695.84	$148,282.16	98%	$0.00

RESOLUTION REQUEST FORM NO. 12

Schedule AA@

NOTICE OF INTENT TO FILL VACANT POSITION

This notice of intent is filed whenever a department head plans to fill an existing funded position in their budget that is vacated due to a retirement, resignation or termination. This notice may not be used for requests to create a *new* position. *For complete instructions on the procedure to be followed, see the reverse of this form.*

DEPARTMENT HEAD COMPLETES THIS SECTION

Department : Westmount Health Facility

Title of Position : Senior Account Clerk Base salary : $ 27,559.00

Budget code and title : EF.83110.100 110 Westmount, Fiscal Service Office, Management & Supervision - Salaries - Regular $ 49,114.00

This position is vacated due to: ☐ Retirement ☐ Resignation ☐ Termination ☒ Promotion ☐ Other

Employee No. 7810

COMMISSIONER OF ADMINISTRATIVE & FISCAL SERVICES COMPLETES THIS SECTION

Name of Committee Date

☐ The Commissioner has no objection to the filling of the vacancy.

☐ The Commissioner objects to the filling of the vacancy.

Commissioner Signature _____

SUPERVISORY COMMITTEE COMPLETES THIS SECTION

Name of Committee Date

☐ The committee has no objection to the filling of the vacancy.

☐ The committee objects to the filling of the vacancy and will be sending a resolution to the full board to have the position removed from the budget.

Ranking Committee Member Signature _____

PERSONNEL COMMITTEE COMPLETES THIS SECTION

Date

☐ The Personnel Committee has no objection to the filling of the vacancy.

☐ The Personnel Committee objects to the filling of the vacancy and will be sending a resolution to the full board to have the position removed from the budget.

Ranking Committee Member Signature _____

WESTMOUNT HEALTH FACILITY

A SKILLED NURSING HOME operated by Warren County

42 GURNEY LANE - QUEENSBURY, NY 12804
Phone: (518)761-6540 Fax: (518) 761-6590

Barbara B. Taggart
Administrator

POSITION AVAILABLE: Senior Acount Clerk

This individual is responsible for all Accounts Payable. It is vital to Westmount's fiscal services department that this position be filled.

Barbara B. Taggart, Administrator

RESOLUTION REQUEST FORM NO. 12

Schedule AA@

NOTICE OF INTENT TO FILL VACANT POSITION

This notice of intent is filed whenever a department head plans to fill an existing funded position in their budget that is vacated due to a retirement, resignation or termination. This notice may not be used for requests to create a *new* position. *For complete instructions on the procedure to be followed, see the reverse of this form.*

DEPARTMENT HEAD COMPLETES THIS SECTION

Department : Westmount Health Facility

Title of Position : Health Facility Office Records Specialist Base salary : $ 33,590.00

Budget code and title : EF.83110.100 110 Westmount, Fiscal Service Office, Management & Supervision - Salaries - Regular $ 49,114.00

This position is vacated due to: ☒ Retirement ☐ Resignation ☐ Termination ☐ Promotion ☐ Other

Employee No. 6807

COMMISSIONER OF ADMINISTRATIVE & FISCAL SERVICES COMPLETES THIS SECTION

Name of Committee Date

☐ The Commissioner has no objection to the filling of the vacancy.

☐ The Commissioner objects to the filling of the vacancy.

Commissioner Signature _____

SUPERVISORY COMMITTEE COMPLETES THIS SECTION

Name of Committee Date

☐ The committee has no objection to the filling of the vacancy.

☐ The committee objects to the filling of the vacancy and will be sending a resolution to the full board to have the position removed from the budget.

Ranking Committee Member Signature _____

PERSONNEL COMMITTEE COMPLETES THIS SECTION

Date

☐ The Personnel Committee has no objection to the filling of the vacancy.

☐ The Personnel Committee objects to the filling of the vacancy and will be sending a resolution to the full board to have the position removed from the budget.

WESTMOUNT CURRENT STAFFING LEVELS - MARCH 2008

		POSITIONS	CURRENT STAFF	EMPLOYEE STATUS
7AM - 3PM	RN F/T	4	4	
	RN P/T	1	0	
	LPN F/T	3	3	
	CNA F/T	18	18	
	CNA P/T	2	2	
	SUBTOTALS	28	27	
3PM - 11PM	RN F/T	1	1	
	RN Relief F/T	1	0	
	LPN F/T	3	3	
	CNA F/T	12	12	
	PCP	1	1	
	SUBTOTALS	18	17	
11PM - 7AM	RN F/T	1	1	
	RN Relief F/T	1	0	
	LPN F/T	3	3	
	CNA F/T	8	8	
	SUBTOTALS	13	12	
	GRAND TOTALS	**59**	**53**	
Per-Diems	RN Per-diem		7	
	LPN Per-diem		12	
	CNA Per-diem		6	
	TOTALS	0	25	

WESTMOUNT HEALTH FACILITY
42 GURNEY LANE
QUEENSBURY, N.Y. 12804

March 27, 2008

#4100	Nursing Administration	3.70 Hours - Overtime
#4101	RN Supervisors	62.70 Hours – Overtime
#4102	RN	26.90 Hours – Overtime
#4103	LPN	41.70 Hours – Overtime
#4104	CNA	242.10 Hours – Overtime
#4105	Activities	0.00 Hours - Overtime
#4109	Dietary	34.75 Hours – Overtime
#4110	Maintenance	9.40 Hours – Overtime
#4111	Housekeeping	8.00 Hours – Overtime
#4112	Laundry	0.00 Hours – Overtime
#4114	Fiscal Services	56.10 Hours – Overtime

Report Dates –2/18/08 – 3/23/08.

State of New York
Department of Health

Capital District Regional Office Frear Building One Fulton Street Troy, NY 12180-3218 (518) 408-5300
Richard F. Daines, M.D.
Commissioner

March 21, 2008

Barbara Taggart, Administrator
Westmount Health Facility
42 Gurney Lane
Queensbury, NY 12804

Facility: **Westmount Health Facility**
Medicare Provider #: **33-5549**
Survey Exit Date: **02/19/2008**
Type of Survey: **Recertification**

Dear Ms. Taggart:

This office has reviewed the Plan of Correction (POC) as amended from the above referenced survey and determined that the POC is acceptable.

As a result of this decision, a post-survey revisit may be conducted to validate that the facility has made the corrections required.

Please contact me at (518) 408-5372 if you have any questions about the survey results.

Sincerely,

Mary Beth Ryan

Mary Beth Ryan
LTC Program Manager
Capital District Regional Office

cc: Matthew Sokol, Chairman

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I260	415.26 Organization and Administration This Regulation is not met as evidenced by: (8) The operator shall ensure that the certified nurse aide regularly attends inservice education programs provided for all personnel and that the programs shall include the following: (i) A portion of each individual's annual inservice education as required by subparagraph (iv) of this paragraph shall be based upon the outcome of the individual's annual performance review as specified in paragraph (7) of this section, and address the areas of weakness in the individual's performance; (ii) Inservice education must also address the special needs of the residents in the facility, including the care of the cognitively impaired; (iii) Written records shall be maintained which indicate the content of and attendance at each inservice training program and the outcomes of the performance review; and (iv) Each certified nurse aide shall attend and be compensated for inservice education sufficient to ensure the continuing competence of the nurse aide of not less than six hours of inservice education in every six month period. Based on review of the Facility Survey Report (FSR), employee personnel files and interview with a staff member, the facility did not have a documentation system in place to ensure that the required 6 hour of inservice education is completed every 6 months for 3 of 3 Certified Nurse Assistant (CNA) reviewed during the standard recertification survey. Specifically, the	I260	1260 415.26 ORGANIZATION AND ADMINISTRATION IN ADDITION TO THE GENERAL IN-SERVICE TRACKING RECORD, AN INDIVIDUAL IN-SERVICE RECORD WILL BE ADDED TO EACH EMPLOY-EE'S FOLDER TO ENSURE THAT THE 6 HOURS OF REQUIRED IN-SERVICE EDUCATION IS COMPLETED EVERY 6 MONTHS AND ACCURATELY DOCU-MENTED. THE RESIDENT CARE COORDINATOR WILL CONDUCT AN AUDIT WEEKLY X 4, THEN MONTHLY X 5, THEN AS DIRECTED BY THE QA COMMITTEE TO ENSURE COMPLETION. THE DIRECTOR OF NURSING WILL BE RESPONSIBLE FOR OVERALL COM-PLIANCE. 3/7/08 POC accepted. 03/21/2008 KRW	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I260	Continued From page 1	I260		
	facility was not able to provide documentation or evidence that each CNA received the 6 hours of required inservice education in a 6 month period. This resulted in no actual harm with the potential for less than minimal harm that is not immediate jeoparyd. This is evidenced by the following: The Facility Survey Report (FSR) reviewed on 2/19/08, noted a "yes" response to the question on page 26 that 6 hours of paid inservice training every six months to each CNA. This form also included from January 2007 through December 2007 a list of inservices that totaled 35 of various topics. From January 1, through June 30, 2008 note that 8 hours and 50 minutes of inservice education was provided and from July,1 through December 31, 2008 note that at least of 10 hours of education was completed. The employee CNA personnel files were reviewed on 2/19/08, and there was no documentation included in the file relating to inservice hours. The Director of Nursing (DON) was asked on 2/19/08 at 1:35 pm to provide evidence or documentation showing that each CNA had the required 6 hour training in a 6 month period. The DON stated that the facility did not have the documentation which would demonstrate that the CNA's had received their required in-service training. The DON could not provide any evidence that a system was in place to track each CNA to ensure that six hours of training is provided in a 6 month period. 10 NYCRR 415.26(8)(iv)			
I560	713-1 Standards of Construction for New Existing NH	I560	1560 713-1 STANDARDS OF -CONTINUED ON NEXT PAGE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I560	Continued From page 2	I560	1560 713-1 STANDARDS OF CONSTRUCTION FOR NEW EXISTING NH	

This Regulation is not met as evidenced by:
(h) Ventilating, heating, and air conditioning systems. Such systems shall:

(1) be maintained in good repair and shall be operated in a manner which will not allow for the spread of infection and provide for resident health and comfort; and

(2) be maintained and operated in such manner that air shall not be circulated from resident isolation rooms, laboratories in which work is done in pathology, virology or bacteriology, autopsy rooms, kitchen and dishwashing areas, toilet and bath rooms, janitors' closets and soiled utility rooms or soiled linen rooms, to other parts of the facility.

Based on observation and interview, it was determined that the facility did not provide the proper air pressure relationship between the soiled utility room and adjacent spaces. This area is required to have negative air pressure in relation to adjoining spaces. This room was provided with a positive pressure in relation to the adjoining hall. This resulted in no actual harm with the potential for less than minimal harm that is not immediate jeopardy. This is evidenced by the following:

The main soiled utility room was observed on 2/14/08 at 11:00 am. This room was provided with only supply air ventilation and as such lacks the required negative air pressure in relation to adjacent areas.

In an interview, concurrent with the survey observation, on 2/14/08 at 11:00 am the Director

THE SYSTEMIC CHANGES REQUIRED FOR NEGATIVE AIR PRESSURE IN THE SOILED UTILITY ROOM INCLUDE:

THE INSTALLATION OF AN APPROPRIATELY SIZED EXHAUST VENTILATOR AT THE CEILING LEVEL OF THE SOILED UTILITY ROOM. FLEXIBLE DUCK WORK ANCHORED TO THE ROOF DECKING WILL BE ATTACHED FROM THE EXHAUST VENTILATOR TO THE INTERIOR DAMPER CONNECTION. THE DAMPER CONNECTION WILL BE INSTALLED IN A CONCRETE WALL LOCATED WITHIN THIS ROOM WHICH WILL PROVIDE EXHAUST VENTILATION (NEGATIVE AIR PRESSURE) TO THE EXTERIOR OF THIS FACILITY. 3/21/08

THE INSTALLATION OF THE EXHAUST VENTILATION SYSTEM PROJECT IN THE SOILED UTILITY ROOM WILL BE MONITORED WEEKLY BY REPORTS FOR COMPLIANCE BY THE DIRECTOR OF ENVIRONMENTAL SERVICES AND MONTHLY TO THE FACILITY QA/QI COMMITTEE UNTIL COMPLETION. THIS REPORTING WILL CONTINUE FOR THREE MONTHS AND THEN THE QA/QI COMMITTEE WILL DETERMINE FREQUENCY. ALL PROJECT REPORTS WILL BE SUBMITTED TO THE ADMINISTRATOR.
-CONTINUED ON NEXT PAGE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I560	Continued From page 3 of Maintenance stated that this room lacked the required negative air pressure in relation to adjacent areas. 10NYCRR 713-1.18 (d)(2)((ii)	I560	1560 713-1 STANDARDS OF CONSTRUCTION FOR NEW EXISTING NH -CONTINUED THE ENVIRONMENTAL SERVICES DIRECTOR WILL BE RESPONSIBLE FOR CONTINUED COMPLIANCE. POC accepted. 03/21/2008 (KPM)	4/8/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined that the facility did not assure protection of hazardous areas from other areas of the building by fire rated construction. The soiled utility room wall which separates it from the common area hallway was not fully constructed up to the roof decking. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy. This is evidenced by the following: The main soiled utility room wall which separates it from the exit hallway space was constructed of sheet rock. This wall was not fully constructed up to the roof decking as areas of the wall terminated two feet below the level of the roof decking. The Maintenance Director interviewed at this time on 2/14/08 stated that this wall was constructed 2 or 3 years ago.	K 029	K 029 NFPA 101 LIFE SAFETY CODE STANDARD MEASURES WHICH WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. THE MEASURES WHICH WILL BE PUT INTO PLACE INCLUDE: CONSTRUCTING WITH 1" SHEET ROCK AN ADDITIONAL WALL APPROXIMATELY 2 FOOT IN HEIGHT BELOW THE ROOF DECKING IN THE SOILED UTILITY ROOM. THIS ADDITIONAL CONSTRUCTED WALL WILL MATCH UP TO THE EXISTING WALL CURRENTLY IN PLACE. 3/28/08 ALL VISIBLE PENETRATIONS WITHIN THE SOILED UTILITY ROOM WALLS WILL BE SEALED WITH A FOUR HOUR RATED FIRE BARRIER SEALANT. 4/4/08 THE FACILITY COMPLIANCE WILL BE MONITORED UTILIZING THE FOLLOWING QUALITY ASSURANCE SYSTEM. A CONSTRUCTION PROGRESS REPORT WILL BE PROVIDED TO THE MONTHLY QA/QI COMMITTEE AND TO THE ADMINISTRATOR BY THE ENVIRONMENTAL SERVICES DIRECTOR. THE -CONTINUED ON NEXT PAGE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara B. Taggart — TITLE: Administrator — (X6) DATE: 3/13/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 ~~2000 LSC, 19.3.2.1,~~ 10 NYCRR 415.29 (a)(2), 711.2 (a)(1) 1997 LSC 13-3.2.1	K 029	K 029 NFPA 101 LIFE SAFETY ~~CODE STANDARD~~ -CONTINUED CONSTRUCTION PROGRESS REPORTS WILL CONTINUE FOR TWO MONTHS AND THEN THE QA/QI COMMITTEE WILL DETERMINE FREQUENCY. THE ENVIRONMENTAL SERVICES DIRECTOR WILL BE RESPONSIBLE FOR CONSTRUCTION COMPLIANCE. POC accepted as amended 3 administrate Kenneth R Mazur 03/21/2008 KRM	4/1/08 ~~5/1/08~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS ALL CURRENT EMPLOYEES HAVE BEEN SCREENED THROUGH THE STATE NURSE AIDE REGISTRY AND THERE WERE NO NEGATIVE FINDINGS. TO ENSURE THAT FACILITY DOES NOT EMPLOY INDIVIDUALS WHO HAVE BEEN FOUND GUILTY OF ABUSE, NEGLECT, OR MISTREATING RESIDENTS, THE "NEW EMPLOYEE CHECKLIST" HAS BEEN REVISED TO INCLUDE TWO REGISTRY CHECKS FOR ALL EMPLOYEES; ONE WHEN THE APPLICATION IS SUBMITTED AND ONE JUST PRIOR TO ORIENTATION. THIS WILL MAKE CERTAIN THAT THE MOST CURRENT INFORMATION IS ON RECORD FOR EVERY EMPLOYEE. WHEN COMPLETED, ALL "CHECKLISTS" WILL BE SUBMITTED TO THE DIRECTOR OF NURSING FOR SIGNATURE. THE RESIDENT CARE COORDINATOR WILL CONDUCT AN AUDIT WEEKLY X 4, THEN MONTHLY X 5, THEN AS DIRECTED BY THE QA COMMITTEE TO ENSURE COMPLETION. THE DIRECTOR OF NURSING WILL BE RESPONSIBLE FOR OVERALL COMPLIANCE. QAC Accepted MBR 3/20/08	2/21/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 by: Based on employee record review and staff interview, the facility did not thoroughly screen employees prior to hiring for four (Finding #1) of five new employees files reviewed during the standard recertification survey. Specifically, the facility did not thoroughly screen new employees prior to hiring for abuse, mistreatment and neglect through the State Nurse Aide Registry or licensing authorities. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy. This is evidenced by the following information: Finding #1: During a review of personnel records for newly hired employees, it was noted that for 5 records, the state nurse aide registry was not completed. During an interview on 2/14/08 at 11:00 am the Director of Nursing and the Administrative support staff assigned to conduct the registry checks, both stated that there was no documentation available to indicate that registry checks were completed prior to hire date. Additionally, the facility's policy regarding protection of residents against abuse did not address conducting nurse aide registry or other professional license checks prior to hire. 10 NYCRR 415.4(b)(1)(ii)	F 225		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced	F 253	F 253 483.15(h)(2) HOUSE-KEEPING/MAINTENANCE THE CORRECTIVE ACTION WHICH WILL BE COMPLETED BY HOUSE-KEEPING AND MAINTENANCE TO -CONTINUED ON NEXT PAGE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 2 by: Based on observation and staff interview, it was determined that the facility did not provide housekeeping and maintenance services necessary to maintain floor surfaces and corner guards clean for two (NE and SW) of two units during the standard recertification survey. Specifically, twenty-seven resident room floor surfaces and three doorways of common areas were noted soiled especially at the door jambs. In addition, there were six areas with soiled rubber corner guards on the wall corners. This resulted in no actual harm with the potential for less than minimal harm that is not immediate jeopardy. This is evidenced by the following: 1. Unit NE: ~~During an observation on 2/14/08 at~~ approximately 2:00 pm sixteen resident room floor surfaces in N1, N2, N3, N4, E1, E2, E6, E7, E8, E10, E11, E12, E14, E15, E16, and E17 were soiled and in addition, the floor surfaces in the N smoke barrier doorway and the N bathing area doorway were soiled especially at the door jambs. 2. Unit SE: During an observation on 2/14/08 at approximately 2:15 pm the eleven resident room floor surfaces in W6, W5, S2, S3, S4, S5, S6, S7, S9, S11, S18, and one common area, the W smoke barrier doorway, were soiled especially at the door jambs. The rubber corner guards at the entrances to the main dining room was blackened with soiled residues when observed on 2/19/08 at 11:45 am. The Housekeeping Director was interviewed on 2/19/08 at 11:10 am regarding the floors and	F 253	F 253 483.15(h)(2) HOUSE-KEEPING/MAINTENANCE -CONTINUED MAINTAIN RESIDENT ROOM FLOOR SURFACES, INCLUDING DOOR JAMS, CORNER GUARDS, AND DOORWAYS OF COMMON AREAS ON BOTH NE AND SW UNITS. 1. UNIT NE: FLOOR SURFACES FOR RESIDENT ROOMS, N1, N2, N3, N4, E1, E2, E6, E7, E8, E10, E11, E12, E14, E15, E16, AND E17 WILL BE STRIPPED/CLEANED AND WAXED ACCORDING TO THE FACILITY FLOOR CARE POLICY. PURSUANT TO THE CORRECTIVE ACTIONS, THE FLOOR SURFACES IN THE N SMOKE BARRIER DOORWAY AND THE N BATHING AREA DOORWAY/ DOOR JAMBS WERE CLEANED, REMOVING ANY SOILED AREAS. 2. UNIT SW: FLOOR SURFACES FOR RESIDENT ROOMS, W6, W5, S2, S3, S4, S5, S6, S7, S11, S9 AND S18 WILL BE STRIPPED/CLEANED AND WAXED ACCORDING TO THE FACILITY FLOOR CARE POLICY. THE W SMOKE BARRIER DOORWAY/ COMMON AREA FLOOR SURFACES WERE CLEANED, REMOVING ANY SOILED AREAS. -CONTINUED ON NEXT PAGE	4/11/08 2/20/08 4/14/08 ~~5/14/08~~ as per phone call w admin 03/24/08 @ 9:45 3/5/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 3 stated that the floors were in need of stripping. The Housekeeping Director stated that floor stripping is usually done once a year and buffing and mopping are done two to three times per week.	F 253	F 253 483.15(h)(2) HOUSE-KEEPING/MAINTENANCE -CONTINUED THE RUBBER CORNER GUARDS AT -CONTINUED ON NEXT SHEET	
F 334 SS=B	10 NYCRR 415.5(h)(2) 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that --	F 334	POC accepted 03/21/2008 (KRM) as amended F 334 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZA-TION AN INFORMED VERBAL CONSENT WAS GIVEN BY RESIDENTS # 25, 42, 53, AND 63 TO THE RNs ADMINISTERING THE INFLUENZA VACCINE AND A NOTE HAS BEEN ADDED TO THE CHART. AN IN-FORMED VERBAL CONSENT WAS GIVEN TO THE RN FOR RESIDENT # 30 BY THE RESIDENT'S SON AND A NOTE WAS ADDED TO THE CHART. TO ENSURE THAT EACH RESIDENT AND/OR LEGAL REPRESENTATIVE RECEIVES EDUCATION REGARDING THE BENEFITS AND POTENTIAL SIDE EFFECTS OF VACCINES, THE IMMUNIZATION POLICY HAS BEEN REVISED TO PROVIDE EDUCATIONAL MATERIAL TO AND RECEIVE WRITTEN CONSENT FROM ALL RESIDENTS AND/OR THEIR REPRESENTATIVES PRIOR TO ADMINISTRATION OF ANY VACCINE. THE INFORMED INFLUENZA CONSENT/DECLINE FORM HAS BEEN REVISED TO INCLUDE A SIGNATURE FROM THE RESIDENT -CONTINUED	

F 253 483.15(h)(2) HOUSEKEEPING/MAINTENANCE

CONTINUED:

THE ENTRANCE TO THE MAIN DINING ROOM WERE CLEANED, REMOVING ANY SOILED AREAS.

COMPLETION DATE: 2/19/08

THE FACILITY COMPLIANCE WILL BE MONITORED UTILIZING THE FOLLOWING QUALITY ASSURANCE SYSTEM. A PREVENTATIVE MAINTENANCE AUDIT TOOL WILL BE DEVELOPED TO MONITOR COMPLIANCE IN ORDER TO MAINTAIN A SANITARY, ORDERLY, AND COMFORTABLE INTERIOR FOR ALL RESIDENTS. THE AUDIT TOOL WILL INCLUDE: NE/SW RESIDENT ROOM FLOORS, DOOR JAMS, FACILITY WALL CORNER GUARDS, SMOKE BARRIER DOORWAYS, AND COMMON AREAS. THE AUDIT WILL BE CONDUCTED WEEKLY FOR THREE MONTHS. FINDINGS WILL BE REPORTED TO THE ADMINISTRATOR. IMMEDIATE CORRECTIVE ACTION WILL BE TAKEN IF INDICATED

COMPLETION DATE: 3/12/08

A SUMMARY OF THE AUDIT TOOL DATA WILL BE REPORTED MONTHLY TO THE QA/QI COMMITTEE. THIS REPORTING WILL CONTINUE FOR THREE MONTHS AND THEN THE QA/QI COMMITTEE WILL DETERMINE FREQUENCY. THE HOUSEKEEPING DIRECTOR WILL BE RESPONSIBLE FOR CONTINUED COMPLIANCE.

COMPLETION DATE: ON GOING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 4 (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility did not ensure the resident and/or resident's legal representative was	F 334	F 334 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION -CONTINUED AND/OR RESPONSIBLE PARTY. THE SOCIAL WORKER WILL BE RESPONSIBLE FOR OBTAINING THE CONSENTS ON ADMISSION TO THE FACILITY. THE DIRECTOR OF NURSING WILL BE RESPONSIBLE FOR OBTAINING ANNUAL INFORMED CONSENTS FOR INFLUENZA AND FOR OVERALL TRACKING AND COMPLIANCE. AN AUDIT WILL BE CONDUCTED BY THE CLINICAL NURSE MANAGER WEEKLY X 4, THEN MONTHLY X 5, ON ALL NEW ADMISSIONS TO ENSURE ALL CONSENT FORMS WERE SIGNED AND THEN AS DIRECTED BY THE QA COMMITTEE. POC accepted 03/21/2008 KCPW	3/7/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

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F 334	Continued From page 5 provided education regarding the benefits and potential side effects of the influenza vaccine for five (#25, 30, 42, 53, and 63) of ten residents reviewed for immunizations during the standard recertification survey. Specifically, the issue identified was lack of documented annual informed consent for influenza immunization. This resulted in no actual harm but the potential for less than minimal harm that was not immediate jeopardy. This evidenced by the following: 1. Resident #25: The facility did not ensure that the resident had documented annual education on the benefits and potential side effects of the influenza vaccine prior to receiving the influenza vaccine. The resident was admitted to the facility on 4/28/07 with diagnoses of Parkinson's disease, coronary heart disease, and hyperlipidemia. The Minimum Data Set (MDS) dated 1/1/08 assessed the resident as having intact short and long-term memory with independent decision-making skills. Record review revealed the resident received the influenza vaccine 11/27/07. There was no indication in the medical record that the resident and/or resident's legal representative received education on the benefits and risks of the influenza vaccine. During an interview on 2/15/08 at 11:30 am the Director of Nursing (DON) stated that there was no documentation of annual education provided to the resident and/or resident's legal representative of the benefits and potential side effects of the influenza vaccine. 2. Resident #30:	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 6 The facility did not ensure that the resident and/or legal representative had documented annual education on the benefits and potential side effects of the influenza vaccine prior to receiving the influenza vaccine. The resident was admitted to the facility on 5/13/03 with the diagnoses of dementia, hypertension and gout. The MDS dated 12/11/07 assessed the resident as having short and long-term memory loss with impaired decision-making skills. Record review revealed the resident received the influenza vaccine 11/17/07. There was no indication in the medical record that the resident and/or the resident's legal representative received education on the benefits and risks of the influenza vaccine. During an interview on 2/15/08 at 11:30 am the DON stated that there was no documentation of annual education provided to the resident and/or resident's legal representative on the benefits and potential side effects of the influenza vaccine. 3. Resident #63: The facility did not ensure that the resident and/or the resident's legal representative had documented annual education on the benefits and potential side effects of the influenza vaccine prior to receiving the influenza vaccine. The resident was admitted to the facility on 8/12/05 with the diagnoses of dementia, arterial insufficiency and esophageal obstruction. The MDS dated 12/4/07 assessed the resident as having short-term memory loss with intact long-term memory and impaired decision-making	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 7 skills. Record review revealed the resident received the influenza vaccine on 11/28/07. There was no indication in the medical record that the resident and/or the resident's legal representative received education on the benefits and risks of the influenza vaccine. During an interview on 2/15/08 at 11:30 am the DON stated that there was no documentation of annual education provided to the resident and/or resident's legal representative on the benefits and potential side effects on the influenza immunization. 10NYCRR 415.19(a)(1)	F 334		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F 425 483.60(a),(b) PHARMACY SERVICES RESIDENT #42 RECEIVED THE MEDICATION AS STATED IN THE SOD ON 12/20/07 AT 10:00 PM. TO ENSURE THAT PHARMACEUTICAL SERVICES ARE PROVIDED TO MEET THE NEEDS OF ALL RESIDENTS, ALL NURSES WILL BE RE-IN-SERVICED ON THE POLICY FOR ORDERING AND RECEIVING MEDICATIONS. THE MEDICATION TRACKING FORMS WILL BE PLACED IN EACH MEDICATION ROOM AND AN AUDIT MONITORING THE MEDS ORDERED/ RECEIVED WILL BE CONDUCTED BY THE 11-7 SUPERVISOR DAILY X 2 WEEKS, THEN WEEKLY X 6 WEEKS, -CONTINUED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 8	F 425	F 425 483.60(a), (b) PHARMACY SERVICES -CONTINUED THEN MONTHLY X 4, THEN AS DIRECTED BY THE QA COMMITTEE. THE CLINICAL NURSE SUPERVISOR WILL BE RESPONSIBLE FOR OVER-ALL COMPLIANCE. POC Accepted 3/20/08	4/7/08

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility did not ensure that pharmaceutical services were provided to meet the needs of each resident for 1 (#42) of 10 residents reviewed during the standard recertification survey. Specifically, the facility did not provide and administer an antibiotic to a resident as ordered by the physician in a timely manner. This resulted in no actual harm with the potential for more then minimal harm that is not immediate jeopardy. This is evidenced by the following:

Resident #42
The resident was admitted on 11/14/06 with diagnoses of dehydration, acute renal failure and urinary retention. The Minimum Data Set (MDS) dated 11/13/07 assessed the resident as having short and long-term memory loss with modified independence in decision-making skills. Also, the MDS assessed the resident as frequently incontinent but did have some bladder control.

The nursing note dated 12/19/07 at 2:00 pm documented that a urine culture and sensitivity (C&S) report was reviewed with the physician. This note documented that the urine C&S showed mixed urogenital flora. Also, the resident was noted to continue to complain of burning with urination and an antibiotic, Fostamycin, one dose, was ordered by the physician.

The physician order dated 12/19/07 at 2:00 pm noted an order to give Fostamycin packet times 1 dose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 9	F 425		
	The next nursing note dated 12/20/07 at 1:00 am, noted that the facility was still awaiting the arrival of the Fostamycin from the pharmacy as ordered. Another note dated 12/20/07 stated that the Fostamycin was given at 10:00 pm on 12/20/07, 30 hours after the order was written and the pharmacy was initially contacted. Review of the medication administration record (MAR), showed the medication was given on 12/20/07 at 10:00 pm. In an interview on 2/14/08 at approximately 1:30 pm the Registered Nurse Manager (RNM) stated she called the order into the pharmacy on 12/19/07. She stated the expectation was that the antibiotic would have been received either on the 7:00 pm delivery or the 12:00 am delivery. She stated she was not on the following shifts, but that if an ordered medication did not arrive, it should be called or faxed again to the pharmacy as soon as possible. The RNM stated that the order was faxed again to the pharmacy on 12/20/07 at 3:50 pm. She stated that there was a delay in the resident receiving the antibiotic. In an interview on 2/14/08 at 12:45 pm the Director of Nursing (DON) said that if a medication is not received from the pharmacy, the expectation is that the pharmacy will be notified immediately. The DON said that there was a delay in obtaining the Fostamycin for this resident. 10NYCRR 415.18(a)			
F 460 SS=B	483.70(d)(1)(iv)-(v) RESIDENT ROOMS Bedrooms must be designed or equipped to	F 460	F 460 483.70(d)(1)(iv)-(v) RESIDENT ROOMS -CONTINUED ON NEXT PAGE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 460	Continued From page 10 assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility did not provide window blinds that fully cover the window to assure full visual privacy for each resident on two (Unit NE and Unit SW) of two units during the standard recertification survey. Specifically, fourteen rooms were equipped with vertical blinds that were missing slats. The missing window blind slats caused spaces ranging from 4 inches to 3 feet and as such did not provide full visual privacy. This resulted in no actual harm with the potential for less than minimal harm that is not immediate jeopardy. This is evidenced by the following: 1. Unit NE: During observation of Unit NE on 2/14/08 at approximately 1:10 pm in room E3, the window in this room was equipped with vertical blinds that were missing slats. These missing slats resulted in a space of three feet when the blinds were fully drawn. During an observation of Unit NE on 2/14/08 at approximately 1:10 pm in room E16, the window in this room was equipped with vertical blinds that were missing slats. These missing slats resulted in a space of one foot. The remaining cloth slats were observed shredding.	F 460	F 460 483.70(d)(1)(iv)-(v) RESIDENT ROOMS -CONTINUED CORRECTIVE ACTION FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY CURRENT PRACTICE: ALL RESIDENTS WHO UTILIZE THEIR ROOM WINDOW BLINDS ON UNITS NE/SW FOR PRIVACY HAS THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE. THE FOLLOWING CORRECTIVE ACTIONS HAVE BEEN IMPLEMENTED: 1. UNIT NE: RESIDENT ROOMS E3, E6, E7, E11, E14, E16, AND N3 MISSING/SHREDDED CLOTH VERTICAL BLIND SLATS WERE REPLACED. 2. UNIT SE: RESIDENT ROOMS W4, W6, W7, W9, S2, S4, AND S15 MISSING/SHREDDED CLOTH VERTICAL BLINDS WERE REPLACED. THE FACILITY COMPLIANCE WILL BE MONITORED UTILIZING THE FOLLOWING QUALITY ASSURANCE SYSTEM. A PREVENTATIVE MAINTENANCE AUDIT TOOL WILL BE DEVELOPED TO MONITOR COMPLIANCE FOR THE APPROPRIATE MAINTENANCE OF THE VERTICAL BLINDS -CONTINUED ON NEXT PAGE	2/21/08 2/25/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. BUILDING _____ B. WING _____	02/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMOUNT HEALTH FACILITY	42 GURNEY LANE QUEENSBURY, NY 12804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 460	Continued From page 11 During an observation of Unit NE on 2/14/08 at approximately 1:15 pm, the windows in rooms E6, E7, E11, E14, and N3 were also equipped with vertical blinds that were missing slats. During an interview on 2/14/08 at approximately 1:30 pm the Director of Maintenance stated that the window vertical blinds were missing slats. 2. Unit SE: During an observation of room W6 on 2/14/08 at 1:45 pm the window in this room was equipped with vertical blinds that were missing slats. These missing slats resulted in a 14 inch space when the curtain was fully closed. During an observation of Unit SE on 2/14/08 at approximately 1:55 pm, the windows in rooms S2, S4, S15, W4, W7 and W9 were also equipped with vertical blinds that were missing slats. During an interview on 2/14/08 at approximately 1:55 pm the Director of Maintenance stated that the window vertical blinds were missing slats. 10 NYCRR 415.29	F 460	F 460 483.70(d)(1)(iv)-(v) RESIDENT ROOMS -CONTINUED LOCATED IN THE WINDOWS IN RESIDENTS' ROOMS. THE AUDIT TOOL WILL BE CONDUCTED MONTHLY FOR THREE MONTHS. FINDINGS WILL BE REPORTED TO THE ADMINISTRATOR. IMMEDIATE CORRECTIVE ACTION WILL BE TAKEN IF INDICATED. A SUMMARY OF THE AUDIT TOOL DATA WILL BE REPORTED MONTHLY TO THE QA/QI COMMITTEE. THIS REPORTING WILL CONTINUE FOR THREE MONTHS AND THEN THE QA/QI COMMITTEE WILL DETERMINE FREQUENCY. THE ENVIRONMENTAL SERVICES DIRECTOR WILL BE RESPONSIBLE FOR COMPLIANCE. POC accepted 03/21/2008 (CRM)	3/6/08 ON GOING

COUNTRYSIDE ADULT HOME
353 Schroon River Road
Warrensburg, New York 12885

Agenda for committee meeting 3/28/08

2007 budget review report by Kathy Baker

Request for resolution to pay Siemem's for work performed between Jan. 30, 2008 and Feb. 25, 2008.

Heat has been a problem for a long time and recently it was brought to this administrator's attention that the previous maintenance mechanic's fix to the situation was to continually push the reset to make the boiler run. Since he is no longer in the building I have been called in as well as Skip Besaw several times because we had no heat.

D&E technologies were here 11/7/07, 2/5/08, and again 2/19/08. In between times Bob Morehouse reportedly changed / replaced a few filters, gaskets, a circulating pump ect. On the 2/19 visit by Tom the D & E tech I was told that he had been telling Bob for the last 2 years that he needed to "fix the problem and stop just using the reset" he also claimed at that time he was just "baby setting the system because" he couldn't get it to shut off while he was here. He also mentioned that he thought it was a control issue and didn't feel the controls could properly run that boiler. He did explain this to Skip who in turn called Bob St. John from Siemen's.

Bob St. John was here on Jan. 30th, 2008 (in the middle of a snow storm) because Bob Morehouse had called them and left word that he (Bob St.John) "needed to get up here, we had no heat" when Mr. St.John arrived he found it was not a control issue at that time, it was air in the line where Bobby had changed a circulator pump the day before and did not properly bleed the lines. This call was $509.85.

We continued to have problems with the heat Bob Morehouse called D&E in on 2/5/08 and he reported they made "some small adjustments". During the next week we had problems and Bob had been instructed by Skip to change filters and put additive into the fuel because they also noted at least 34 inches of water in the tank Bob had admitted to Skip that he never added any additive to the fuel in the time the tank was installed (4 or 5 years).

Bob Morehouse has not been in the building since 2/7/08 and we continued to have problems.

Skip Besaw has been covering and he was called in on several occasions; 2/11/08, 2/12/08 @ 1am and again 7:30am, 2/13/08 @ 9:30pm, 2/16/08 @ 6:30am, 2/17/08 @3:30am, 2/18/08 @ 8pm both myself and Skip were called in. Skip called D&E on 2/19 who told him it was a control issue so Skip called Siemen's that same day Bob St. John came out at 4pm and at this time they noted someone had been adjusting the temp. on the control panel so they reprogrammed it taking Bob Morehouse out and giving sole accessibility to me and Skip. This call was $556.00. Normally this would not have had a charge if there was something wrong with the program but it appears as though someone

WARREN COUNTY

Budget Performance Report

Through Date: 12/31/2007

Account Number		Adopted Budget	Budget Amendments	Amended Budget	Current Month Transactions	YTD Encumbrances	YTD Transactions	Budget Less YTD Transactions	% Used / Rec'd	Prior Year Total
Fund: A - General										
Revenue										
Department: 6030 - Countryside Adult Home										
	Account Classification - Departmental Income									
1830	Repay - Adult Care, Pub Inst	500,000.00	0.00	500,000.00	177,722.35	0.00	657,603.86	(157,603.86)	132%	706,149.77
1831	Res. Hall - Activities Fund	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
1892	Charges for Soc. Ser. Empl	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
	Departmental Income Totals:	$500,000.00	$0.00	$500,000.00	$177,722.35	$0.00	$657,603.86	($157,603.86)	132%	$706,149.77
	Account Classification - State Aid									
3630	Adult Care Priv. Inst.	645,369.00	22,182.00	667,551.00	227,138.00	0.00	482,986.00	184,565.00	72%	538,634.00
	State Aid Totals:	$645,369.00	$22,182.00	$667,551.00	$227,138.00	$0.00	$482,986.00	$184,565.00	72%	$538,634.00
	Account Classification - Sale of Property And Compensation for Loss									
2665	Sale of Equipment	0.00	0.00	0.00	0.00	0.00	3,840.00	(3,840.00)	+++	0.00
2680.01	Insurance Recoveries-Countryside	0.00	12,018.00	12,018.00	0.00	0.00	12,018.00	0.00	100%	0.00
	Sale of Property And Compensation for Loss Totals:	$0.00	$12,018.00	$12,018.00	$0.00	$0.00	$15,858.00	($3,840.00)	132%	$0.00
Department Total: Countryside Adult Home		$1,145,369.00	$34,200.00	$1,179,569.00	$404,860.35	$0.00	$1,156,447.86	$23,121.14	98%	$1,244,783.77
Expenses										
Department: 6030 - Countryside Adult Home										
	Account Classification - Personal Services									
110	Salaries - Regular	869,853.00	84,367.00	954,220.00	95,423.55	0.00	949,947.35	4,272.65	100%	895,894.15
120	Salaries - Overtime	28,348.00	10,495.00	38,843.00	2,986.08	0.00	35,774.22	3,068.78	92%	46,482.73
130	Salaries - Part Time	22,784.00	(20,897.00)	1,887.00	0.00	0.00	1,886.54	0.46	100%	915.60
140	Salaries - Sick Leave Incentive	4,000.00	400.00	4,400.00	3,800.00	0.00	3,800.00	600.00	86%	0.00
	Personal Services Totals:	$924,985.00	$74,365.00	$999,350.00	$102,209.63	$0.00	$991,408.11	$7,941.89	99%	$943,292.48
	Account Classification - Equipment									
210	Furniture/Furnishings	16,273.00	(5,276.00)	10,997.00	0.00	0.00	10,996.89	0.11	100%	2,575.48
220	Office Equipment	0.00	58.00	58.00	0.00	0.00	57.10	0.90	98%	612.14
230	Automotive Equipment	16,000.00	22,584.00	38,584.00	21,903.57	0.00	38,096.85	487.15	99%	4,098.24
260	Other Equipment	1,650.00	596.00	2,246.00	168.00	0.00	2,245.69	0.31	100%	2,558.43
270	Lawn & Landscaping	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	1,982.86
	Equipment Totals:	$33,923.00	$17,962.00	$51,885.00	$22,071.57	$0.00	$51,396.53	$488.47	99%	$11,827.15
	Account Classification - Contractual Expense									
410	Supplies	26,000.00	3,746.00	29,746.00	363.07	0.00	29,187.87	558.13	98%	29,100.15

WARREN COUNTY

Budget Performance Report

Through Date: 12/31/2007

Account Number	Rent-Building/Property	Adopted Budget	Budget Amendments	Amended Budget	Current Month Transactions	YTD Encumbrances	YTD Transactions	Budget Less YTD Transactions	% Used / Rec'd	Prior Year Total
411		0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
413	Repair & Maint.-Bldg/Property	42,000.00	(6,749.00)	35,251.00	1,096.50	0.00	33,076.06	2,174.94	94%	31,074.39
415	Electricity	38,000.00	(310.00)	37,690.00	9,151.92	0.00	37,422.11	267.89	99%	39,449.14
416	Oil & Gas-Heating	35,500.00	(2,680.00)	32,820.00	4,591.21	0.00	31,588.69	1,231.31	96%	32,584.82
418	Ins-General Liability	11,945.00	(300.00)	11,645.00	0.00	0.00	10,327.68	1,317.32	89%	10,784.26
421	Equipment Rental	2,500.00	0.00	2,500.00	162.05	0.00	2,181.73	318.27	87%	1,458.90
422	Repair/Maint-Equipment	3,000.00	0.00	3,000.00	777.25	0.00	2,377.31	622.69	79%	752.64
423	Telephone	3,500.00	540.00	4,040.00	361.30	0.00	3,425.99	614.01	85%	3,324.36
424	Postage	500.00	0.00	500.00	10.42	0.00	472.42	27.58	94%	466.42
426	Subscriptions	200.00	0.00	200.00	0.00	0.00	175.25	24.75	88%	175.25
428	Data Processing & Internet Fees	1,200.00	0.00	1,200.00	84.96	0.00	1,019.52	180.48	85%	1,028.52
432	Special Project Supply	4,500.00	(2,575.00)	1,925.00	283.30	0.00	1,895.57	29.43	98%	2,367.40
434	Allowances	30,000.00	(4,650.00)	25,350.00	3,550.00	0.00	24,500.00	850.00	97%	24,900.00
435	Medical Fees	500.00	(150.00)	350.00	0.00	0.00	0.00	350.00	0%	385.05
436	Advertising Fees	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	246.00
437	Consulting Fees	14,000.00	(150.00)	13,850.00	1,967.92	0.00	13,326.53	523.47	96%	13,642.70
439	Misc Fees & Expenses	5,000.00	2,360.00	7,360.00	5,202.38	0.00	6,836.94	523.06	93%	3,586.07
440	Legal/Transcript Fees	1,000.00	(525.00)	475.00	0.00	0.00	0.00	475.00	0%	1,663.65
441	Auto-Supplies & Repair	5,000.00	0.00	5,000.00	270.89	0.00	1,394.27	3,605.73	28%	5,904.94
442	Automotive - Gas & Oil	3,000.00	3,000.00	6,000.00	348.47	0.00	5,414.50	585.50	90%	5,814.52
444	Travel/Education/Conference	1,300.00	(803.00)	497.00	0.00	0.00	497.00	0.00	100%	1,218.00
445	Foods	80,000.00	(2,329.00)	77,671.00	7,804.88	0.00	72,540.16	5,130.84	93%	77,608.56
451	Medical Supply Expense	10,000.00	1,200.00	11,200.00	263.96	0.00	10,358.11	841.89	92%	10,019.99
453	Uniforms & Clothing	300.00	(137.00)	163.00	0.00	0.00	99.99	63.01	61%	239.98
470	Contract	5,000.00	12,400.00	17,400.00	838.74	0.00	17,284.32	115.68	99%	6,712.55
	Contractual Expense Totals:	$323,945.00	$1,888.00	$325,833.00	$37,129.22	$0.00	$305,402.02	$20,430.98	94%	$304,508.26
	Account Classification - Indebtedness									
710	Interest-Indebtedness	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00
	Indebtedness Totals:	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	+++	$0.00
	Account Classification - Employee Benefits									
810	Retirement	92,053.00	(4,028.00)	88,025.00	58,415.63	0.00	79,981.38	8,043.62	91%	85,379.50
830	Social Security	58,338.00	0.00	58,338.00	6,042.32	0.00	59,764.93	(1,426.93)	102%	57,655.18
831	Medicare Contribution	13,644.00	0.00	13,644.00	1,413.17	0.00	13,976.99	(332.99)	102%	13,483.36
840	Workmen's Compensation	18,953.00	0.00	18,953.00	0.00	0.00	18,952.13	0.87	100%	19,850.32
850	Unemployment Insurance	2,000.00	(552.00)	1,448.00	1,163.75	0.00	1,163.75	284.25	80%	5,351.50
855	Disability	3,000.00	0.00	3,000.00	2,914.83	0.00	3,000.00	0.00	100%	1,123.40
860	Hospitalization	235,740.00	(33,844.00)	201,896.00	11,830.30	0.00	197,867.17	4,028.83	98%	205,834.88
865	Dental Insurance	3,888.00	552.00	4,440.00	0.00	0.00	4,440.00	0.00	100%	3,924.00

WARREN COUNTY

Budget Performance Report

Through Date: 12/31/2007

Account Number	Adopted Budget	Budget Amendments	Amended Budget	Current Month Transactions	YTD Encumbrances	YTD Transactions	Budget Less YTD Transactions	% Used / Rec'd	Prior Year Total
Employee Benefits Totals:	$427,616.00	($37,872.00)	$389,744.00	$61,760.00	$0.00	$379,146.35	$10,597.65	97%	$392,602.14
Department Total: Countryside Adult Home	$1,710,469.00	$56,343.00	$1,766,812.00	$243,190.42	$0.00	$1,727,353.01	$39,458.99	98%	$1,652,230.03
Revenue Total:	$1,145,369.00	$34,200.00	$1,179,569.00	$404,860.35	$0.00	$1,156,447.86	$23,121.14	98%	$1,244,783.77
Expense Total:	$1,710,469.00	$56,343.00	$1,766,812.00	$243,190.42	$0.00	$1,727,353.01	$39,458.99	98%	$1,652,230.03
Fund Total: General	($565,100.00)	($22,143.00)	($587,243.00)	$161,669.93	$0.00	($570,905.15)	($16,337.85)		($407,446.26)
Revenue Grand Total:	$1,145,369.00	$34,200.00	$1,179,569.00	$404,860.35	$0.00	$1,156,447.86	$23,121.14	98%	$1,244,783.77
Expense Grand Total:	$1,710,469.00	$56,343.00	$1,766,812.00	$243,190.42	$0.00	$1,727,353.01	$39,458.99	98%	$1,652,230.03
Grand Total:	($565,100.00)	($22,143.00)	($587,243.00)	$161,669.93	$0.00	($570,905.15)	($16,337.85)		($407,446.26)

WARREN COUNTY

Budget Performance Report

Through Date: 03/26/2008

Account Number		Adopted Budget	Budget Amendments	Amended Budget	Current Month Transactions	YTD Encumbrances	YTD Transactions	Budget Less YTD Transactions	% Used / Rec'd	Prior Year To
Fund: A - General										
Revenue										
Department: 6030 - Countryside Adult Home										
	Account Classification - Departmental Income									
1830	Repay - Adult Care, Pub Inst	500,000.00	0.00	500,000.00	47,822.29	0.00	95,931.46	404,068.54	19%	657,603.
1831	Res. Hall - Activities Fund	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.
1892	Charges for Soc. Ser. Empl	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.
	Departmental Income Totals:	$500,000.00	$0.00	$500,000.00	$47,822.29	$0.00	$95,931.46	$404,068.54	19%	$657,603.
	Account Classification - State Aid									
3630	Adult Care Priv. Inst.	612,917.00	0.00	612,917.00	0.00	0.00	0.00	612,917.00	0%	482,986.
	State Aid Totals:	$612,917.00	$0.00	$612,917.00	$0.00	$0.00	$0.00	$612,917.00	0%	$482,986.
	Account Classification - Sale of Property And Compensation for Loss									
2665	Sale of Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	3,840.
2680.01	Insurance Recoveries-Countryside	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	12,018.
	Sale of Property And Compensation for Loss Totals:	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	+++	$15,858.
Department Total: Countryside Adult Home		$1,112,917.00	$0.00	$1,112,917.00	$47,822.29	$0.00	$95,931.46	$1,016,985.54	9%	$1,156,447.8
Expenses										
Department: 6030 - Countryside Adult Home										
	Account Classification - Personal Services									
110	Salaries - Regular	896,945.00	0.00	896,945.00	36,666.54	0.00	165,030.28	731,914.72	18%	949,947.3
120	Salaries - Overtime	28,348.00	0.00	28,348.00	2,487.25	0.00	7,649.65	20,698.35	27%	35,774.2
130	Salaries - Part Time	11,853.00	0.00	11,853.00	0.00	0.00	0.00	11,853.00	0%	1,886.5
140	Salaries - Sick Leave Incentive	4,000.00	0.00	4,000.00	0.00	0.00	0.00	4,000.00	0%	3,800.0
	Personal Services Totals:	$941,146.00	$0.00	$941,146.00	$39,373.79	$0.00	$172,679.93	$768,466.07	18%	$991,408.1
	Account Classification - Equipment									
210	Furniture/Furnishings	15,000.00	0.00	15,000.00	0.00	0.00	0.00	15,000.00	0%	10,996.89
220	Office Equipment	300.00	0.00	300.00	0.00	0.00	108.68	191.32	36%	57.10
230	Automotive Equipment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	38,096.85
260	Other Equipment	5,250.00	0.00	5,250.00	0.00	0.00	188.97	5,061.03	4%	2,245.69
270	Lawn & Landscaping	250.00	0.00	250.00	0.00	0.00	0.00	250.00	0%	0.00
	Equipment Totals:	$20,800.00	$0.00	$20,800.00	$0.00	$0.00	$297.65	$20,502.35	1%	$51,396.53
	Account Classification - Contractual Expense									
410	Supplies	30,000.00	0.00	30,000.00	2,571.97	2,257.99	6,783.32	20,958.69	30%	29,187.87
411	Rent-Building/Property	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.00

Budget Performance Report

Through Date: 03/26/2008

Account Number		Adopted Budget	Budget Amendments	Amended Budget	Current Month Transactions	YTD Encumbrances	YTD Transactions	Budget Less YTD Transactions	% Used / Rec'd	Prior Year To
413	Repair & Maint.-Bldg/Property	38,000.00	0.00	38,000.00	994.07	3,671.68	6,104.66	28,223.66	26%	33,076.
415	Electricity	40,000.00	0.00	40,000.00	2,665.98	0.00	6,021.54	33,978.46	15%	37,422.
416	Oil & Gas-Heating	37,000.00	0.00	37,000.00	2,743.12	0.00	14,719.06	22,280.94	40%	31,588.
418	Ins-General Liability	11,950.00	0.00	11,950.00	0.00	0.00	7,196.41	4,753.59	60%	10,327.
421	Equipment Rental	2,100.00	0.00	2,100.00	162.05	0.00	486.15	1,613.85	23%	2,181.
422	Repair/Maint-Equipment	2,000.00	0.00	2,000.00	0.00	0.00	640.34	1,359.66	32%	2,377.
423	Telephone	3,500.00	0.00	3,500.00	319.45	0.00	767.10	2,732.90	22%	3,425.
424	Postage	750.00	0.00	750.00	120.68	0.00	120.68	629.32	16%	472.
426	Subscriptions	200.00	0.00	200.00	0.00	0.00	0.00	200.00	0%	175.
428	Data Processing & Internet Fees	1,700.00	0.00	1,700.00	84.96	0.00	254.88	1,445.12	15%	1,019.
432	Special Project Supply	4,500.00	0.00	4,500.00	92.69	0.00	92.69	4,407.31	2%	1,895.
434	Allowances	30,000.00	0.00	30,000.00	2,400.00	0.00	6,700.00	23,300.00	22%	24,500.
435	Medical Fees	500.00	0.00	500.00	0.00	0.00	0.00	500.00	0%	0.
436	Advertising Fees	1,000.00	0.00	1,000.00	0.00	0.00	0.00	1,000.00	0%	0.
437	Consulting Fees	14,500.00	0.00	14,500.00	941.64	0.00	2,315.28	12,184.72	16%	13,326.
439	Misc Fees & Expenses	6,360.00	0.00	6,360.00	75.00	0.00	287.70	6,072.30	5%	6,836.
440	Legal/Transcript Fees	1,000.00	0.00	1,000.00	0.00	0.00	0.00	1,000.00	0%	0.
441	Auto-Supplies & Repair	5,000.00	0.00	5,000.00	445.45	0.00	827.25	4,172.75	17%	1,394.
442	Automotive - Gas & Oil	6,000.00	0.00	6,000.00	0.00	0.00	678.31	5,321.69	11%	5,414.
444	Travel/Education/Conference	1,200.00	0.00	1,200.00	0.00	0.00	0.00	1,200.00	0%	497.
445	Foods	80,000.00	0.00	80,000.00	4,438.33	6,219.53	15,298.77	58,481.70	27%	72,540.
451	Medical Supply Expense	10,000.00	0.00	10,000.00	124.76	0.00	526.85	9,473.15	5%	10,358.
453	Uniforms & Clothing	360.00	0.00	360.00	0.00	0.00	269.96	90.04	75%	99.
470	Contract	19,000.00	0.00	19,000.00	422.40	0.00	825.71	18,174.29	4%	17,284.
	Contractual Expense Totals:	$346,620.00	$0.00	$346,620.00	$18,602.55	$12,149.20	$70,916.66	$263,554.14	24%	$305,402.
	Account Classification - Indebtedness									
710	Interest-Indebtedness	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+++	0.
	Indebtedness Totals:	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	+++	$0.
	Account Classification - Employee Benefits									
810	Retirement	84,703.00	0.00	84,703.00	0.00	0.00	0.00	84,703.00	0%	79,981.
830	Social Security	58,351.00	0.00	58,351.00	0.00	0.00	1,118.39	57,232.61	2%	59,764.
831	Medicare Contribution	13,647.00	0.00	13,647.00	0.00	0.00	261.56	13,385.44	2%	13,976.
840	Workmen's Compensation	10,947.00	0.00	10,947.00	0.00	0.00	10,946.34	0.66	100%	18,952.
850	Unemployment Insurance	5,000.00	0.00	5,000.00	0.00	0.00	0.00	5,000.00	0%	1,163.
855	Disability	3,000.00	0.00	3,000.00	0.00	0.00	0.00	3,000.00	0%	3,000.
860	Hospitalization	200,489.00	0.00	200,489.00	18,556.99	0.00	73,952.44	126,536.56	37%	197,867.
865	Dental Insurance	4,464.00	0.00	4,464.00	386.00	0.00	1,544.00	2,920.00	35%	4,440.
	Employee Benefits Totals:	$380,601.00	$0.00	$380,601.00	$18,942.99	$0.00	$87,822.73	$292,778.27	23%	$379,146.

WARREN COUNTY

Budget Performance Report

Through Date: 03/26/2008

Account Number	Adopted Budget	Budget Amendments	Amended Budget	Current Month Transactions	YTD Encumbrances	YTD Transactions	Budget Less YTD Transactions	% Used / Rec'd	Prior Year To
Department Total: Countryside Adult Home	$1,689,167.00	$0.00	$1,689,167.00	$76,919.33	$12,149.20	$331,716.97	$1,345,300.83	20%	$1,727,353.
Revenue Total:	$1,112,917.00	$0.00	$1,112,917.00	$47,822.29	$0.00	$95,931.46	$1,016,985.54	9%	$1,156,447.
Expense Total:	$1,689,167.00	$0.00	$1,689,167.00	$76,919.33	$12,149.20	$331,716.97	$1,345,300.83	20%	$1,727,353.
Fund Total: General	($576,250.00)	$0.00	($576,250.00)	($29,097.04)	($12,149.20)	($235,785.51)	($328,315.29)		($570,905.1
Revenue Grand Total:	$1,112,917.00	$0.00	$1,112,917.00	$47,822.29	$0.00	$95,931.46	$1,016,985.54	9%	$1,156,447.
Expense Grand Total:	$1,689,167.00	$0.00	$1,689,167.00	$76,919.33	$12,149.20	$331,716.97	$1,345,300.83	20%	$1,727,353.
Grand Total:	($576,250.00)	$0.00	($576,250.00)	($29,097.04)	($12,149.20)	($235,785.51)	($328,315.29)		($570,905.1

D & E Technologies, Inc.
120 Broadway
Menands, NY 12204
Phone: (518) 463-8703
Fax: (518) 463-8903

SERVICE WORK ORDER

WO# _____

Date 2-19-08 Job # _____ Custm. # _____

Invoice To: Countryside

Address:

Customer P.O. #	Sales Tax %	Cty I.D.

Equipment, Make, Model, Serial, Voltage, etc.

Boilers

Work Performed

Found oil filter on the booster pumps was plugged. Got that done and the unit is running o.k. The computer has not brought the other boiler on while I was here. The boiler keeps shutting off on high limit. I did not get enough time today to look into why. The control guy is going to look into it tonight about some of the issues. I think the controls are not properly set up for the boilers

QTY.	MATERIAL DESCRIPTION (PRINT)	Unit	Extended

RESOLUTION REQUEST FORM NO. 20

MISCELLANEOUS

**Please List All Other Requests Not Covered by Previous Resolution Request Forms Here. Please attach any backup information available and be as detailed as possible.*

DEPARTMENT NAME: Countryside Adult Home

DATE: 3/28/2008

(a) Purpose of Request: Pay Siemen's for emergency repairs in the amount of $2,451.74 performed to the heating system at Countryside. We have funs available in acct. 413 Repair & Maint.-Bldg / Property

(b) Details: We had no heat then the boiler kept shutting off. D & E Technology did not fix the problem after 3 visits, Seimen's was called in for service to the controlls and asked to advise on the repair to the boiler. Seimen's repaired the control on the boiler which is not covered under the same contract as the monitoring system. D & E stated the problem had something to do with the control but did not fix that portion. They did perform maintenance such as filter changes. Since Seimen's repaired the control issue and the boiler issue the work finalized on Feb. 25,2008 we have had no further breakdown in the heat.

(c) Previous Resolution Number:

Warren County Board of Supervisors

RESOLUTION NO. 214 OF 2008

Resolution introduced by Supervisors Stec, Belden, O'Connor, Bentley, Tessier, Champagne, VanNess, Kenny and Merlino

ACCEPTING PROPOSAL AND AUTHORIZING AGREEMENT WITH DELTA HEALTH TECHNOLOGIES, LLC FOR POINT OF CARE SOFTWARE SYSTEM FOR THE WARREN COUNTY HEALTH SERVICES DEPARTMENT (WC 40-08) - HEALTH SERVICES DEPARTMENT

WHEREAS, the Purchasing Agent has advertised for Request for Proposals for a Point of Care Software System for the Warren County Health Services Department (WC 40-08), and

WHEREAS, the Director of Public Health/Patient Services has issued correspondence recommending award of the agreement to Delta Health Technologies, LLC, with the lowest responsible Proposal, now, therefore, be it

RESOLVED, that Warren County enter into an agreement with Delta Health Technologies, LLC, 400 Lakemont Park Boulevard, Altoona, Pennsylvania 16602, pursuant to the terms and provisions of the Specifications (WC 40-08) and Proposal, for a total cost of Five Hundred Forty Thousand Four Hundred Seventy-Five Dollars ($540,475), for a term commencing on April 1, 2008 and terminating upon sixty (60) days notice by either party, and the Chairman of the Board of Supervisors be, and hereby is, authorized to execute the agreement in the form approved by the County Attorney, and be it further

RESOLVED, that the funds for said agreement shall be expended from Capital Project No. H282.9550 280 - Point of Care.

PLEASANT VALLEY

A Residential Health Care Facility
Adult Home
Adult Medical Day Care
New York State Licensed, Medicare Certified
4573 State Route 40
Argyle, New York 12809

Douglas E. Cosey
Administrator
dcosey@co.washington.ny.us

Tel: (518) 638-8274
Fax (518) 638-6420

November 5, 2007

Ms. Brenda Brown-Hayes, Director
Countryside Adult Home
353 Schroon River Road
Warrensburg, NY 12885

Dear Brenda:

I would like to thank you for the time you took this past Friday to show Ellen Kent and me your facility. We were both very impressed with your home and the level of organization. You certainly have a handle on your operation and it shows. Most importantly, your residents look happy and healthy.

Thank you again for your willingness to share your experiences and insights. It will be very helpful to us in refining our internal systems.

Sincerely,

Douglas E. Cosey
PV Administrator

cc: Hal Payne, Warren County Administrator
Ellen Kent, PV Adult Home Director
file

Warren County Health Services
Health Services Committee Meeting
March 28, 2008
Information Submitted By: Patricia Auer, DPH/DPS

Pending Items

Approval of Minutes of February 22, 2008 Health Services Committee Meeting
2007-2008 Tobacco Usage Survey Report
We have not yet received the results of this survey from the Council for Prevention. If the committee members are agreeable, we can take it off the pending items list, and I will bring the report to the committee when we receive it.
Point of Care Update
The bids received as a result of the Request for Proposal (RFP) were opened on March 6, 2008. As you may recall from the last meeting, requests were sent to four vendors, all of who had made a presentation to us during the last several months regarding their systems. Three vendors returned proposals. The bonding and contract has now been approved, and Delta Healthcare Technologies, the lowest bidder will be the company providing the system. The total amount bonded for the project will be $542,975 which includes the contract with Delta for $540,475, and $2,500 that will be used to cover 8 new phone lines for remote access ($1,000) and a UPS for the systems ($1,500) which will be provided by the Warren County IT Department.
The two other quotes submitted were:
McKesson: $576, 378
Home Care Net: Was not able to meet all the specifications stated in the RFP. (i.e. the system is unable to interface with the telemedicine program)
As soon as the contract with Delta is in place, we will begin the process of transitioning to the new system. We will keep you updated on our progress. Tammie DeLorenzo, our Coordinator of Clinical and Fiscal Informatics, is now in our department and she will be involved in the transition to the new system. Since implementation of the Point of Care System is a major goal for Health Services this year and is a significant expenditure of funds, we will provide monthly updates to the committee regarding the progress of the initiative.
Emergency Response and Preparedness Activities
Please see the attached report of monthly activities.

New Business

Request Resolution:
To renew the contract with the New York State Department of Health to receive funding for the Children With Special Health Care Needs in the amount of $18,883 for the contract year October 1, 2008 – September 30, 2009.
Rationale:
This is the earliest we have ever received this grant for renewal, but whatever, the grant is to be refunded so that's a good thing! Funds are paid quarterly upon voucher submission and reports that contract deliverables are being met.

Request Resolution:
To renew grant with the New York State Department of Health Lead Poisoning Prevention Program for the contract year April 1, 2008-March 31, 2009 in the amount of $25,000.
Rationale:
This grant is renewed annually, and the amounts are paid quarterly upon voucher submission and quarterly reports indicating that contract deliverables are being met according to the submitted plan.

Request Committee Approval:
To expend funds from our staff education budget in the amount of $150.00 to cover the registration fee to allow our Communicable Disease Coordinator to attend a five-day training course in Albany (May 12-15) for Infection Prevention Practitioners. The program is being funded by the New York State Department of Health, Hospital Acquired Infection Reporting Program. No overnight travel is needed and the employee would drive a health services fleet vehicle. Meals are included as part of the conference.

Request Resolution:
To develop a contract agreement with Adam Willis to provide Physical Therapy Services.
Rationale:
This individual has worked with us in the past a part of a therapy group. He is now seeking an individual Business Associate agreement, and is interested in treating adult patients. Physical therapists we have recently recruited seem to prefer working with children, and this individual is interested in providing services to adults.

Request Referral to Personnel Committee:
For authorization to backfill a full time nurse position.
Rationale:
The position is funded in the 2008 Budget, and is a revenue generating position, as nursing services are billable. The vacancy has occurred due to the nurse resigning to assume a full time school nurse position. She has indicated that she is interested in remaining in a per diem status and would be able to assist during the summer months to cover when many of the nurses take vacation time, and we are always short staffed. The position is a Community Health Nurse (Registered Nurse with at least 2 years of public health/home health care experience), Grade 20: Base Salary$40,647 but as has been discussed and agreed upon the last time we had to fill a nurse vacancy, due to the shortage of nurses, we would request to place the new nurse in the slot where her education and experience level falls according to the contract and amend the table of organization accordingly.
We would also request consideration to begin posting for the position right away as nurses are not easily recruited, and the position has already been vacant since March 9th. We realize that the position ultimately cannot be filled until after the Board of Supervisors' Meeting April 18th, but if we can post, interview and maybe recruit a candidate, by the time the individual would even be eligible to start (i.e. would have to give notice at present employment) it would be after the Personnel Committee and Board of Supervisors Meeting in the best of circumstances.

Request Resolution:
To renew the contract with Outcome Concept Systems, Inc. in order to continue to receive the Benchmark Business Intelligence Elite browser based tool (BBI) and the Electronic Performance Improvement Consultant (EPIC) for a period to commence April 1, 2007 and be terminable with 30 days written notice in the amount of $5,000 per year.
Rationale:
These funds have been budgeted in the 2008 Budget, and the contract is necessary in order to measure the quality of care provided to our patients. It also ties into the Pay for Performance reimbursement methodologies. In the event the contract fee changes we will return to the Health Services Committee to review the terms of the agreement.
Request Resolution:
To accept a one time grant in the amount of $1,500.00 from Sanofi Pasteur Inc. to be used for staff education of nurses in regard to travel medicine.
Rationale:
As you may recall, researching the possibility of offering some type of travel clinic to provide immunizations to individuals planning to travel was one of our goals for 2008. This grant will be utilized to purchase an on site day long training for our clinic nurse team with a consultant who has extensive knowledge in travel medicine and conducting travel clinics. We are hopeful that after the training we will be in a realistic position to evaluate whether offering a travel clinic is a viable and fiscally advisable option for Warren County Health Services. By our next meeting we expect we will be requesting the contract for the individual who will be providing the training.
As for why Sanofi offers grants, they sell vaccine. However, we are under no obligation to purchase any more vaccines than we already do from them. Currently, they are the company where we purchase five different types of immunizations we provide.
I checked with Trish Nenninger, 2nd Assistant County Attorney, who will make sure there is no problem accepting this grant.
Report of Revenues and Expenditures 2007
Please see the attached information.
Tammie DeLorenzo will be present at the meeting to answer questions.

Informational Item

New York State Health Commissioner, Richard Daines, MD, will be visiting our agency on April 8th, along with several other Department of Health Staff, and an individual from NYSAC. We will be showcasing The Community Health Assessment Project, which has been a joint initiative with other counties comprising the Rural Health Network, and our Telemedicine and Wound Care Management Programs. Following the presentations, Dr. Daines will be making a home visit with one of our nurses to a patient who is receiving telemedicine services. Dr. Rugge will also be here to provide a short overview of medical care in rural areas, and the importance of the team collaboration between public health and primary care physicians.
The week of April 7th is Public Health Week, where many activities are planned throughout the state. It is anticipated that there will be local and state press coverage, and we are proud of the services we are able to provide for our residents.
Attachments:
Emergency Response and Preparedness Activities for March 2008
Revenues and Expenditures for 2007

Warren County Health Services

1340 State Route 9, Lake George NY 12845

Patricia Auer, Director
Phone: 518-761-6580 / Fax: 518-761-6422
Email: auerp@co.warren.ny.us

Health Services Committee Meeting
Date: MARCH 28, 2008
Emergency Response and Preparedness Activities

DATE	*TYPE*	*SUBJECT*	*ATTENDEES*
3/4/08	Blast Fax	To Providers re: Tatoos and Associated Skin Infections	Ginelle Jones
3/6/08	Mailing	To Providers re: PH Satisfaction Survey; and included laminated info re: Ticks and Lyme Disease	Ginelle Jones, Angela Meade
3/11/08	Meeting	BT Coordinators Meeting - Ballston Spa	Angela Meade
3/12/08	Meeting	With Mike Gates/Corrections re: Pan Flu	Barb Orton
3/13/08	Meeting	Washington County BT Committee	Barb Orton
3/18/08	Blast Fax	To Providers re: Great Escape Gastroenteritis	Ginelle Jones
3/19/08	Blast Fax	To Providers from NYSDOH re: Great Escape Gastrointestinal Outbreak	Ginelle Jones
3/19/08	Tabletop	Structural collapse during construction of Emergency Care Center; and Alternate Care Site Plan	Barb Orton
3/20/08	Training	White Powder Protocols with Wadsworth Lab	Barb Orton, et. al (attendees in file)
3/21/08	Blast Fax	Press release and questionnaire re: Great Escape Gastroenteritis	Ginelle Jones

Ginelle Jones
Assistant Director Public Health
Phone: 518-761-6580
Fax: 518-761-6422
Email: jonesg@co.warren.ny.us

Sharon Schaldone
Assistant Director Home Care
Phone: 518-761-6415
Fax: 518-761-6562
Email: schaldones@co.warren.ny.us

Tawn Driscoll
Fiscal Manager
Phone: 518-761-6415
Fax: 518-761-6562
Email: driscollt@co.warren.ny.us

WARREN COUNTY BUDGET ANALYSIS

REVENUE AND EXPENDITURES FOR 2007 AS OF 3/26/2008 12:25:32 PM

FUND(S): A, CL, D, DM, EF, GI, MS, SD, V

CODE(S): 4010, 4011, 4013, 4016, 4018, 4046, 4054, 4189, 9061, 4025

EXPENSES	2007 BUDGETED	2007 YTD ACTUAL	2006 Prior Year Totals
Salaries - Regular	$2,977,890.00	$2,852,447.30	$2,749,048.51
Salaries - Overtime	$96,506.00	$197,947.99	$181,972.69
Salaries - Part Time	$364,316.00	$309,053.46	$237,576.39
Salaries - Sick Leave Incentive	$0.00	$1,200.00	$0.00
100's PERSONAL SERVICES	$3,438,712.00	$3,360,648.75	$3,168,597.59
200's EQUIPMENT	$75,985.00	$74,772.07	$301,397.39
400's CONTRACTUAL	$8,209,444.00	$8,237,868.51	$8,033,832.92
800's EMPLOYEE BENEFITS	$62,249.00	$59,089.23	$45,227.13
TOTALS	**$11,786,390.00**	**$11,732,378.56**	**$11,549,055.03**

REVENUES	2007 BUDGETED	2007 YTD ACTUAL	2006 Prior Year Totals
	$11,451,042.00	$11,034,645.66	$10,954,586.78

Note: Revenues of $549,527 for the Early Intervention and Preschool programs and $44,146 for 4th quarter GPHW grant have been accrued for 2007. These revenues will be posted to the General Ledger as of 12/31/07.

It should be noted that while some increases in expenses such as salaries and payments to Contract Therapists are reflected above, our reimbursement from the State for these mandated programs remains the same throughout 2007. The state has not increased reimbursement fees at this time.

WARREN COUNTY BUDGET ANALYSIS

REVENUE AND EXPENDITURES FOR 2008 AS OF 3/26/2008 12:06:42 PM

FUND(S): A, CL, D, DM, EF, GI, MS, SD, V

CODE(S): 4010, 4011, 4013, 4016, 4018, 4046, 4054, 4189, 9061, 4025

EXPENSES	2008 BUDGETED	2008 YTD ACTUAL	2007 Prior Year Totals
Salaries - Regular	$3,089,937.00	$500,359.09	$2,852,447.30
Salaries - Overtime	$172,838.00	$43,969.62	$197,947.99
Salaries - Part Time	$355,495.00	$47,934.86	$309,053.46
Salaries - Sick Leave Incentive	$0.00	$0.00	$1,200.00
100's PERSONAL SERVICES	$3,618,270.00	$592,263.57	$3,360,648.75
200's EQUIPMENT	$40,000.00	$2,152.61	$74,772.07
400's CONTRACTUAL	$8,532,128.00	$1,095,372.34	$8,237,868.51
800's EMPLOYEE BENEFITS	$63,091.00	$57,326.76	$59,089.23
TOTALS	**$12,253,489.00**	**$1,747,115.28**	**$11,732,378.56**

REVENUES	2008 BUDGETED	2008 YTD ACTUAL	2007 Prior Year Totals
	$11,658,892.00	$275,253.55	$11,034,645.66

Note: Revenues for 2008 at this time do not reflect any CHHA and LTC billing. January is to be closed within the next week.

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: March 28, 2008

(a) Purpose of Contract Change: To renew contract with NYSDOH Children With Special Health Care Needs Program to allow receipt of continued funding in the amount of $25,000.00

(b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: 586/2007, see attached

(c) Name of Contractor: NYSDOH Division of Family Health Fiscal Unit

(d) Address of Contractor: Empire State Plaza, Corning Tower, Rm 878, Albany, NY 12237

(e) Contractor's Contact Person and Telephone Number: Kristin Kuentzel, 474-4569, kxk02@health.state.ny.us

(f) Commencement Date of Amendment: 10/1/08

(g) Termination Date of Extension: 9/30/09

(h) Payment Provisions: Quarterly voucher submission, payable after work plan approved

i) lump sum amount
ii) hourly rate amount
iii) total amount not to exceed
iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.

(i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount: A4054.0060.4451 Physically Handicapped Children - Early Intervention

Warren County Board of Supervisors

RESOLUTION NO. 586 OF 2007

Resolution introduced by Supervisors Mason, Sheehan, Haskell, F. Thomas, Tessier, Champagne and Sokol

AUTHORIZING AGREEMENT CONTINUING CONTRACTUAL RELATIONSHIP WITH NEW YORK STATE DEPARTMENT OF HEALTH FOR FUNDING OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM - HEALTH SERVICES DEPARTMENT

RESOLVED, that Warren County continue the contractual relationship (the previous contract being authorized by Resolution No. 702 of 2006) with New York State Department of Health, Division of Family Health, Fiscal Unit, Corning Tower, Room 878, The Governor Nelson A. Rockefeller Empire State Plaza, Albany, New York 12237, for funding for the Children with Special Health Care Needs (CSHCN) Program, for a term commencing October 1, ~~2007~~ 2008 and terminating September 30, ~~2008~~ 2009, for an amount not to exceed Eighteen Thousand Eight Hundred Eighty-Three Dollars ($18,883), and the Chairman of the Board of Supervisors be, and hereby is, authorized to execute an agreement in the form approved by the County Attorney.

Z:\2007Docs\Resos\026-07.wpd\dlm\740A-067
9/11/07

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

March 12, 2008

Patricia Auer
Director of Public Health & Patient Services
Warren County on behalf of Warren County Health Services
1340 State Route 9
Lake George, New York 12845

Dear Ms. Auer:

Enclosed please find budget and workplan forms to renew your Children with Special Health Care Needs program contract number C-021586 for the period October 1, 2008 – September 30, 2009 in the amount of $18,533. If you decide to accept the funds described in the paragraph below, your budget amount would be $18,883. When your budget and workplan are approved, you will receive contract signature pages under separate cover.

This amount includes additional funding in the amount of $350 that must be used to support families of children with special health care needs (CSHCN) and youth and young adults with special health care needs (YAYASHCN) in program involvement, empowerment or leadership activities. These nonpersonal service funds can be utilized for supports which include but are not limited to: project or meetings which are for consumers (families of CSHCN and YAYASHCN); consumer stipends for involvement as participants or presenters in meetings or trainings; or consumer travel which facilitates participation in leadership, empowerment or program development activities. These funds are to be utilized to support families of CSHCN and YAYASHCN across the spectrum of birth to 21 years. These funds can not be used to support consumer involvement in Local Early Intervention Coordinating Council meetings or activities that are solely focused on the birth to three population. These funds can not be utilized for staff development.

If you decide to accept the additional $350, you must complete the attached justification Form 3b as well as page 6 of the workplan under the section "Consumer Involvement". If you choose not to accept the additional funding, indicate "0" in the "Cost" column and "Declined" in the "Description/Justification" column on Form 3b. If funds are declined, no additional information on page 6 of the workplan is required.

Please complete the necessary forms and return two copies of your contract submission package to my attention by **April 11, 2008** to:

New York State Department of Health
Division of Family Health Fiscal Unit
Empire State Plaza
Corning Tower, Room 878
Albany, NY 12237-0657

If you have fiscal questions or require assistance, please contact Kristin Kuentzel at (518) 474-4569 or by e-mail at kxk02@health.state.ny.us. Programmatic workplan issues should be discussed with Sue Slade at (518) 474-2001 or by e-mail at sjs11@health.state.ny.us. Thank you.

Sincerely,

Kristin Kuentzel for
Garry Wood
Health Program Administrator 3
Fiscal Unit
Division of Family Health

Enclosure

PART 1

Children with Special Health Care Needs Program

Instructions For Completing Operating Budget and Funding Request

(Tables A, A-1and A-2)

IN COMPLETING TABLES A-1 THROUGH A-4, LIST THE PERSONAL SERVICES AND NONPERSONAL SERVICES THAT SUPPORT THIS INITIATIVE, *EVEN IF NO FUNDING IS BEING REQUESTED FROM NYS*.

TABLE A (Operating Budget and Funding Request Summary Sheet)

This table will summarize the sub and grand totals on Tables A-1and A-2.

TABLE A-1 (Personal Services):

List ALL personnel working on this grant, even if no funding is being requested from NYS. Failure to list ALL personnel on Table A-1 may result in the disapproval of future requests for budget revisions.

Column No.:

(1) Personal Services: List **ALL** personnel working on the grant, even if **no** funding is being requested from NYS.

(2) Annual Salary - enter the amount of funding needed to support this position for 12 months on a full-time basis, regardless of funding source.

(3) Number of Months Funded - enter the number of months the position will be funded by this grant. Note: the number of months may be less than the contract period, but cannot exceed the number of months in the contract period.

(4) Percent (%) FTE - enter the % of time the incumbent will work on the grant on a full-time basis. One (.1) FTE is based on the number of hours worked in one week (e.g. 40 hour workweek). To determine a % FTE, divide the hours per week spent on the project, by the number of hours in the workweek. For example: given a 40 hour workweek, an individual working 10 hours per week on the project spends .25 percent of his/her time on the project (i.e. 10/40 = .25) Please show in decimal form.

(5) Total Expenses - To calculate, multiply the full-time annualized salary by the % FTE. Multiply the result by the number of months funded divided by 12 (i.e. salary X % FTE X # of months funded / 12).

(6) Amount requested from NYS - enter the amount of total expenses (see Column 6) requested to be reimbursed by NYS.

(7) Other Sources - include amounts expected to be received from all other sources, including Medicaid Administrative Funding (for services other than transportation as provided for in LCM-23), local appropriation, in-kind, 3rd party billing, revenue earned from items funded by this grant, etc. A separate amount should be indicated for each source of funding specified in column 8.

(8) Specify Other Sources - specify the source of funds for each amt. shown in Column 7.

See Subtotal Salaries line - enter the subtotal of the salaries in Columns 5, 6 and 7.

See Fringe Benefits - show the percentage of Fringe Benefits derived on Fringe Benefit Rate Form 2. Multiply this rate by the sub-total of the salaries in Column 5 and enter the result on the Fringe Benefits line in Column 5. In Column 7 on this budget line, sum the dollar amounts in Columns 5 and 6.

See Subtotal PS line - sum the "Sub-Total Salaries" amounts and "Fringe Benefits" amounts shown in Columns 5, 6 and 7.

TABLE A-2 (Nonpersonal Services)

List ALL nonpersonal expenses related to this grant, even if no funding is being requested from NYS. Failure to list ALL nonpersonal expenses on Table A-2 may result in the disapproval of future requests for budget revisions.

Column No.:

(1) Nonpersonal Services - List **ALL** expenses related to this grant, even if **no** money is being reimbursed from NYS.

(2) Total Expenses - The total expenses for all items should be indicated. This column must equal the sum total of the figures in columns 3 and 4.

(3) Amount Requested from New York State - Direct funding requests to New York State will be indicated by all of the amounts in this column.

(4) Other Sources of Funds - include amounts expected to be received from all other sources including Medicaid Administrative Funding (for services other than transportation as provided for in LCM-23), local appropriation, in-kind, 3rd party billing, revenue earned from items funded by this grant, etc. A separate dollar amount should be indicated for each source of funding specified in column 5.

(5) Specify Other Sources - Specify the source of funds for each amt. shown in Column 4.

NOTE: THE OPERATING BUDGET AND FUNDING REQUEST MUST BE ACCOMPANIED BY THE BUDGET NARRATIVE/JUSTIFICATION FORMS.

Contractor: Warren County o/b/o Warren County Health Services

Contract No: C-021586

APPENDIX B

TABLE A

CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM

OPERATING BUDGET AND FUNDING REQUEST

SUMMARY SHEET

October 1, 2008 - September 30, 2009

	Total Expenses	Amount Requested From NYS	Funds From Other Sources	Specify Other Sources of Funds
Personal Services (PS)				
Sub-Total PS				
Nonpersonal Services				
Sub-Total Nonpersonal Services				
GRAND TOTAL:				

Note: Federal funds are being used to support this contract. The Code of Federal Domestic Assistance (CFDA) numbers for this funding are: CSHCN Program (93.994)

Contractor: Warren County o/b/o Warren County Health Services

Contract No.: C-021586

APPENDIX B
TABLE A-1
CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
OPERATING BUDGET AND FUNDING REQUEST
OCTOBER 1, 2008- SEPTEMBER 30, 2009

PERSONAL SERVICES (PS)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
List the title of **ALL** personnel working on the grant, even if no funding is being requested from NYS:	Annual Salary	# of Months Funded	% FTE Annual (please show in decimal form (e.g. .25)	Total Expenses	Amount Requested From NYS	Funds From Other Sources	Specify Other Sources of Funds
Sub-Total Salaries							
Fringe Benefit Rate							
Sub-Total PS							

Contractor: Warren County o/b/o Warren County Health Services

Contract No.: C-021586

APPENDIX B
TABLE A-2
CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
OPERATING BUDGET AND FUNDING REQUEST
OCTOBER 1, 2008 - SEPTEMBER 30, 2009

NONPERSONAL SERVICES (OTPS)			[(2) - (3)]	
(1)	(2)	(3)	(4)	(5)
List ALL expenses related to this initiative even if no funding is being requested from NYS:	Total Expenses	Amount Requested From NYS	Other Sources of Funds	Specify Other Sources of Funds
Printing and Copying				
Postage				
Supplies (including software)				
Telephone				
Travel:				
In-State				
Out-of-State				
Training				
Equipment				
Purchased Services:				
Subcontractors				
Consultants				
Other (please itemize):				
Total Nonpersonal Services				
Total Personal Services				
GRAND TOTAL (total expenses from Tables A-1 and A-2)				

PART 2

Children with Special Health Care Needs Program

BUDGET NARRATIVE/JUSTIFICATION FORMS

Contractor Name: Warren County o/b/o Warren County Health Services

Contract No.: C- 021586

Contract Period: October 1, 2008 through September 30, 2009

Contact Person: _____

Telephone Number: ( ) _____

Fax Number: ( ) _____

****

Using the attached format, provide a justification for the expenses included in each category listed in the operating budget and funding request, Tables A through A-2. The justification must include various items of expense (and estimated costs) that comprise the amount requested for each budget category, and an explanation of how the expenses listed relate to the goals and objectives of the program.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM

BUDGET NARRATIVE/JUSTIFICATION INSTRUCTIONS

Forms 1, 2, 3, 3a, 3b and Workplan:

Forms 1 and 2 Personal Services:

Form 1 must include a description for each position contained in Table A-1. The percentage of time spent on various duties, where appropriate, must be included. Contracted, consultant or per-diem staff are not to be included in the description/justification. These expenses should be shown as consultant or contractual services under the "Nonpersonal Services" section of Form 3.

Forms 3, 3a and 3b Nonpersonal Services:

Supplies and Materials (including software):

Definition: **Any item with a per unit cost of $500 or less.** Software cost should be broken-out separately under supplies, regardless of cost. Provide a delineation of the items of expense and estimated cost of each along with a justification of their need. Note: Some supplies may be consolidated under the heading of Office Supplies, Medical Supplies, etc.

Equipment:

Definition: **Any item with a per unit cost of $500 or more.** Provide a delineation of each piece of equipment and estimated cost along with a justification of need. Explanations should be more detailed if the equipment is unique or if special features are included that justify a higher cost. Note: Software costs should be budgeted under Supplies and Materials and broken-out separately. Also, each item charged to the Equipment line must be reported on the Equipment Inventory Report at the end of the year.

Travel:

Complete Form 3a as appropriate and enter amounts on table A-2.

Consumer Involvement:

Form 3b must list what the $350 funding will be used for, how much will be spent on each activity along with a description/justification of their need. This funding will be listed on Table A-2 under "Nonpersonal Services" as "Consumer Involvement".

Other Expenses:

List any item of expense not included elsewhere in the budget. Items might include: insurance, space occupancy, advertising, etc. Include a justification and allocation methodology for EACH item listed.

Example: Insurance - The total policy for the agency is $5,000. This contract constitutes 15% of the total agency budget, as such, the amount requested is $750.

$150,000 contract amount
$1,000,000 agency budget = 15%
15% x $5,000 = $750

Subcontracts/Consultant Services:

Provide a listing of all subcontracts, including consultant contracts which will support contract deliverables along with a description of the services to be provided. This should include all contracts that support the program even if funded by other sources. Include an estimate of the number of hours to be worked and the rate per hour, if applicable, for subcontracts supported in full or in part with requested funds.

If the subcontractor/consultant has not yet been selected, please indicate **"Not Selected"** under the Subcontractor/Consultant line and provide all other pertinent information.

Note: A copy of the subcontractor/consultant agreement must be submitted before these expenses can be approved for reimbursement.

Workplan

Complete workplan by describing your proposed activities in the workplan areas. Describe the strategy(s) you will use to accomplish the workplan activities and how you plan to measure your progress in the workplan areas.

Contractor: Warren County o/b/o Warren County Health Services

Contract No.: C-021586

CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
BUDGET NARRATIVE/JUSTIFICATION
FORM 1
October 1, 2008 through September 30, 2009

PERSONAL SERVICES (PS):

Title(s)	Incumbent Name(s)	Description/Justification (use additional sheets if necessary)

CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
FRINGE BENEFIT RATE
FORM 2
October 1, 2008 through September 30, 2009

PART A

Does your organization have a federally approved fringe benefit rate?

Yes: _____ If yes, you do **not** have to complete Part B.

Federally Approved Rate:_____ Period of Applicability: _____ Attach copy of Federal Approval - all pages.

No: _____ If no, proceed to Part B.

PART B

Specify the components and percentages comprising the fringe benefit rate.

Note: If positions have different fringe benefit rates, please use an average for all positions.

Component	Rate
F.I.C.A (6.2%) & Medicare Tax (1.45%)	7.65%
Health Insurance	
Unemployment Insurance	
Disability Insurance	
Life Insurance	
Worker's Compensation	
Pension/Retirement	
Other: (delineate)	
*Total Fringe Rate	

*This rate must be equal to the percentage shown in the budget, Appendix B, Table A-1.

Contractor: Warren County o/b/o Warren County Health Services

Contract No.: C-021586

CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
BUDGET NARRATIVE/JUSTIFICATION
FORM 3
October 1, 2008 through September 30, 2009

NONPERSONAL SERVICES (OTPS)

Item(s)	Cost	Description/Justification (use additional sheets if necessary)

Contractor: Warren County o/b/o Warren County Health Services
Contract No.: C-021586

CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
BUDGET NARRATIVE/JUSTIFICATION
FORM 3a
October 1, 2007 through September 30, 2008

PROVIDE A DELINEATION OF THE FUNDING REQUESTED IN EACH OF THE FOLLOWING SUB-CATEGORIES IF APPLICABLE **ATTACHING ADDITIONAL SHEETS AS NECESSARY.**

Staff and Volunteer Travel	Include number of staff, titles of staff and volunteer estimated travel costs (including transportation, lodging and meals for the contract period), and purpose of travel.	$ _____
Out-of-State and Conference Travel	Provide an estimate of the amount you anticipate spending on out-of-state and conference travel along with a delineation of the travel (as noted in the examples below) and a justification of how the travel relates to program objectives. **All** out-of-state travel must have prior approval.	$ _____

Examples:

In-State: Program Coordinator and Data Coordinator to attend 2 related in-State conferences; 2 staff X 2 conferences each X $300 per conference (including transportation, lodging and meals) = $1,200.

Out-of-State: Program Coordinator and Data Coordinator to attend conference (including transportation, lodging and meals) at a cost of $900 per person = $1,800. Note: If the location of the conference is known, it should be indicated. If it is not known, it **must** be submitted with the voucher on which reimbursement is claimed.

TOTAL FUNDING REQUESTED FOR TRAVEL: * $ _____

* Note: The amount shown here must equal the total cost of travel found on Table A-2.

Contractor: Warren County o/b/o Warren County Health Services

Contract No.: C-021586

CONSUMER INVOLVEMENT FUNDS
CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM
BUDGET NARRATIVE/JUSTIFICATION
FORM 3b
October 1, 2008 through September 30, 2009

Item(s)	Cost	Description/Justification (use additional sheets if necessary)

CONTRACTOR NAME: Warren County o/b/o Warren County Health Services
CONTRACT NUMBER: C-021586

APPENDIX D
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
OCTOBER 1, 2008 – SEPTEMBER 30, 2009

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
Information & Referral: Families of CSHCN will receive information and referrals to insurance, health services, and community resources to address their identified needs.	1) 100% of families of CSHCN who are uninsured or underinsured will be provided with information regarding health and dental insurance and gap-filling programs, referred to available public insurance and gap-filling programs, and enrolled as appropriate. 2) 100% of families of CSHCN with health-related needs will be assisted in accessing appropriate community resources.			1) All reported services rendered each quarter will be entered into the CSHCN data application. Ongoing involvement, as in referrals made or in pending status, and/or receipt of needed services will be reflected in the data.	
Data: All data will be reported in a timely manner in accordance with Appendix C, Section II of the Payment and Reporting Contract Requirements.	1) Data will be reported quarterly throughout the year and submitted to the Division of Family Health - Fiscal Unit.			1) Data will be received in the Division of Family Health Fiscal Unit no later than 45 days after the end of the quarter (i.e. 2/14/09 1st quarter, 5/15/09 2nd quarter; 8/14/09 3rd quarter; and 11/14/09 4th quarter).	

CONTRACTOR NAME: Warren County o/b/o Warren County Health Services
CONTRACT NUMBER: C-021586

APPENDIX D
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
OCTOBER 1, 2008 – SEPTEMBER 30, 2009

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
Quality Improvement: Gaps and barriers to access health care and related services and resources for families are identified.	1) Grantee will identify barriers to health care and related services and resources via: contacts with families, (particularly culturally diverse families) and providers; interactions with resources in the community; and involvement in community coalitions, professional organizations and other groups. 2) Grantee will suggest strategy(ies) for addressing identified barriers, including those for culturally diverse families. 3) Grantee will initiate proposed strategy(ies) to the extent possible, review and report progress to overcome the barriers, and permanently implement to the degree possible the strategy(ies) that are effective.			1) The grantee will report for each quarter the barriers encountered and the progress and successes in resolving them.	

CONTRACTOR NAME: Warren County o/b/o Warren County Health Services
CONTRACT NUMBER: C-021586

APPENDIX D
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
OCTOBER 1, 2008 – SEPTEMBER 30, 2009

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
Outreach: Each grantee will perform outreach activities at a minimum of once a quarter.	1) At least quarterly, information about the CSHCN Program is disseminated to the community targeting families (including culturally diverse populations) of CSHCN and providers who serve them. 2) The CSHCN Program will have a culturally and linguistically appropriate current publication to use for outreach. 3) Information about health insurance (including Medicaid, Child Health Plus, and Family Health Plus) and other resources targeting families of CSHCN is disseminated to the community.			1) Outreach efforts are documented in the narrative quarterly report, including target audience, location and medium used. All relevant newly published literature is attached to the quarterly report.	

CONTRACTOR NAME: Warren County o/b/o Warren County Health Services
CONTRACT NUMBER: C-021586

APPENDIX D
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
OCTOBER 1, 2008 – SEPTEMBER 30, 2009

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
Other (Optional): **Please specify if offering any other services. These areas are suggested:**	**If you choose one or more of the optional activity areas, the corresponding objectives apply:**				
Medical Homes: Foster awareness of the medical home concept as defined by the American Academy of Pediatrics (AAP).	1) At least once a year, information is distributed to families and providers about the medical home concept. 2) At least once a year, presentations are offered to families and providers about the medical home concept.			1) Narrative reports will describe the target population, the information distributed, and the quantity of information distributed. 2) Narrative reports will indicate the number of presentations given and the number of participants.	
Staff Development: Staff development opportunities are provided to CSHCN staff to ensure they are an effective resource for families of CSHCN.	1) At least once a year, staff is offered opportunities to learn about available resources, medical diagnoses, cultural competency, and program policy and procedures.			1) Narrative reports will describe staff training and development and note staff attendance.	

APPENDIX D
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) PROGRAM WORKPLAN
OCTOBER 1, 2008 – SEPTEMBER 30, 2009

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
Other (Optional): Please specify if offering any other services. These areas are suggested:					
Lending Library: Print and audio/visual resources will be made available to families and other community members.	1) A lending library of culturally and linquistically appropriate print and audio/visual resources is developed, maintained and made available for families of CSHCN and other community members.			1) Quarterly narrative reports detail the number of individuals served by the lending library.	
Transition: Youth and families are prepared for transition to the adult world of health, learning, living and earning.	1) Effective initially at age 14, paper and electronic culturally appropriate resources are offered to 100% of youth and families regarding transition to adult health care providers, sources of health insurance, and vocational services.			1) Narrative reports describe resources and activities offered for youth and families related to transition.	

APPENDIX D
CSHCN- CONSUMER INVOLVEMENT
OCTOBER 1, 2008 – SEPTEMBER 30, 2009

Program Goals	Objectives	Activities for Goal Accomplishment	Person(s) Responsible	Measurement	Person(s) Responsible
If the additional OTPS funds are accepted, these funds must be utilized for consumer involvement. **Consumer involvement:** Increase consumer (families of CSHCN and youth and young adults with special health care needs) involvement in the local CSHCN Program.	1) At least once during the year, consumers, including those of culturally diverse populations, are involved in meetings, trainings or other types of activities which improve their knowledge, attitudes or skills or enhance program development. 2) Funding is provided for consumer stipends, travel, and attendant and/or childcare expenses while participating in these activities.			1) Narrative reports will document consumer involvement in meetings, trainings or other activities. 2) Quarterly vouchers will document reimbursement for consumer stipends, travel, and attendant and/or child care.	

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: March 28, 2008

(a) Purpose of Contract Change: To renew contract with NYSDOH Childhood Lead Poisoning Prevention Program to allow continued receipt of funding in the amount of $25,000.00

(b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: 301/2007, see attached

(c) Name of Contractor: NYSDOH

(d) Address of Contractor: Empire State Plaza, Corning Tower, Rm 878, Albany, NY 12237

(e) Contractor's Contact Person and Telephone Number: Donna Hoinski, 474-4569

(f) Commencement Date of Amendment: 4/1/08

(g) Termination Date of Extension: 3/31/09

(h) Payment Provisions: Quarterly voucher submission, payable after work plan approved

i) lump sum amount
ii) hourly rate amount
iii) total amount not to exceed
iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.

(i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount: A4018.0020.4457 Paint Poison Prevention

Warren County Board of Supervisors

RESOLUTION NO. 301 OF 2007

Resolution introduced by Supervisors Mason, Sheehan, Haskell, F. Thomas, Tessier, Champagne and Sokol

AUTHORIZING GRANT AGREEMENT RENEWAL WITH NEW YORK STATE DEPARTMENT OF HEALTH FOR CHILDHOOD LEAD POISONING PREVENTION PROGRAM - HEALTH SERVICES DEPARTMENT

RESOLVED, that Warren County enter into a grant agreement renewal (the previous renewal having been authorized by Resolution No. 190 of 2006) with New York State Department of Health, Empire State Plaza, Corning Tower, Room 878, Albany, New York 12237, for the receipt of grant funds for the continuation of a Childhood Lead Poisoning Prevention Program within Warren County, for an amount not less than Twenty-Five Thousand Dollars ($25,000), for a term commencing April 1, ~~2007~~ 2008 and terminating March 31, ~~2008~~ 2009, and the Chairman of the Board of Supervisors be, and hereby is, authorized to execute the said grant agreement renewal in the form approved by the County Attorney.

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5/7/07

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

February 4, 2008

Ginelle Jones, Assistant Director of Public Health
Warren County Health Department
1340 State Route 9
Lake George, NY 12845

Re: C-020637
April 1, 2008 - March 31, 2009

Dear Ms. Jones:

This is to inform you of the Department's intention to provide an award of $25,000.00 for the grant term April 1, 2008 – March 31, 2009 to support the Childhood Lead Poisoning Prevention Program in your county. Funding levels remain contingent upon approval of your work plan and budget. As always, approval of the Office of the State Comptroller is required for contract execution.

All contractors are required to complete the enclosed work plan in its entirety, the format cannot be modified or changed. We will not be able to accept work plan submissions using prior year templates, as all required information will not be included.

A copy of the budget and work plan attachments has also been forwarded to you via e-mail. We are asking that you complete and return the Operating Budget and Funding Request, budget justification forms and work plan to my attention via email by **March 5, 2008** at the following address:

dmh01@health.state.ny.us

When returning via e-mail, please attach budget and work plan pages as WORD or EXCEL documents. Please do not send in PDF format.

I may be reached at (518) 474-4569, please call me if you have any budget related questions, or concerns regarding e-mail submittal of your budget and work plan pages. You may reach Kathy Riviello at (518) 402-5706 with any programmatic questions.

Sincerely,

Donna Hoinski
Health Program Administrator I
Fiscal Unit
Division of Family Health

Enclosures

cc: Kathy Riviello
Lynn Lauzon-Russom

Contractor: Warren County Health Services

Contract No.: C-020637

Appendix B
Table A
CHILDHOOD LEAD POISIONING PREVENTION PROGRAM
OPERATING BUDGET AND FUNDING REQUEST
April 1, 2008 - March 31, 2009

	Total Expense	Amount Requested from NYS	3rd Party	Other Source	Specify other source
Director of Public Health	4,317	0		4,317	
Administrative Asst	6,807	6,807		0	
Asst Dir Public Health	3,215	1,144		2,071	
Public Health Nurse	9,598	9,598		0	
Fiscal Manager	2,487	500		1,987	
Health Educator	736	0		736	
Health Educator	571	0		571	
Fringe Benefits	10,679	6,951		3,728	
Total Personal Services	38,410	25,000		13,410	In-kind contribution
PB testing	300	0		300	
Educational Supplies	200	0		200	
Postage	550	0		550	
Conference/Training	750	0		750	
Repair/Maint of Equip	100	0		100	
Office Supplies	300	0		300	
Total Other Than Personal Services	2,200	0		2,200	
GRAND TOTAL	40,610	25,000		15,610	in-kind contribution

Contractor: Warren County Health Services

Contract No.: C-020637

Appendix B
Table A-1
CHILDHOOD LEAD POISIONING PREVENTION PROGRAM
OPERATING BUDGET AND FUNDING REQUEST
April 1, 2007 - March 31, 2008

PERSONAL SERVICES

Title	Annual Salary	% FTE	# of Mos.	Total Expense	Amount Requested from NYS	3rd Party	Other Source	Specify other source
Director of Public Health	86,337	5%	12	4,317	0		4,317	
Administrative Asst	34,034	20%	12	6,807	6,807		0	
Asst Dir Public Health	64,304	5%	12	3,215	1,144		2,071	
Public Health Nurse	47,990	20%	12	9,598	9,598		0	
Fiscal Manager	49,738	5%	12	2,487	500		1,987	
Health Educator	36,799	2%	12	736	0		736	
Health Educator	28,569	2%	12	571	0		571	
Sub-Total Personal Services				27,731	18,049		9,682	
Fringe Benefits 38.51%				10,679	6,951		3,728	
Total Personal Services				38,410	25,000		13,410	In-kind contribution

Contractor: Warren County Health Services
Contract No.: C-020637

Appendix B
Table A-2
CHILDHOOD LEAD POISIONING PREVENTION PROGRAM
OPERATING BUDGET AND FUNDING REQUEST
April 1, 2008 - March 31, 2009

OTHER THAN PERSONAL SERVICES

	Total Expense	Amount Requested from NYS	3rd Party	Other Source	Specify other source
(list Budgeted Expenses)					
PB testing	300	0		300	
Educational Supplies	200	0		200	
Postage	550	0		550	
Conference/Training	750	0		750	
Repair/Maint of Equip	100	0		100	
Office Supplies	300	0		300	
Total Other Than Personal Services	2,200	0		2,200	in-kind contribution

BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT
FORM B-1
PERSONAL SERVICES

Contractor: Warren County Health Services
Contract Period: April 1, 2008 - March 31, 2009
Contract No.: C-020637

PERSONAL SERVICES

Title	Incumbent	Description
		environmental testing/follow-up Provides materials for health fairs and other community events Provides materials as needed for public inquiry. Salary increase due to union settlement.
Fiscal Manager	Tawn Driscoll	Preparation and monitoring of Lead Budget and Expenses. Submits quarterly Lead Grant Vouchers
Health Educators	Dan Durkee	Dissemination of materials at Health fairs.
	Laura Saffer	Letters, posters,programs to Community such as PTAs,Childcare, Medical Providers, Hardware stores,Toy stores, & Contractors,Building & Codes on Lead Prevention. Salary variance due to hire dates

BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT
FORM B-1
PERSONAL SERVICES

Contractor: Warren County Health Services
Contract Period: April 1, 2008 - March 31, 2009
Contract No.: C-020637

PERSONAL SERVICES

Title	Incumbent	Description
		environmental testing/follow-up Provides materials for health fairs and other community events Provides materials as needed for public inquiry. Salary increase due to union settlement.
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Health Educators	Dan Durkee	Dissemination of materials at Health fairs.
	Laura Saffer	Letters, posters,programs to Community such as PTAs,Childcare, Medical Providers, Hardware stores,Toy stores, & Contractors,Building & Codes on Lead Prevention.
		Salary variance due to hire dates

BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT
FORM B-2
FRINGE BENEFITS

Contractor: Warren County Health Services
Contract Period: April 1, 2008 - March 31, 2009
Contract No: C-020637

FRINGE BENEFITS

Component	Rate
F.I.C.A	6.18%
Medicare Tax	1.36%
Health Insurance	18.97%
Life Insurance	0.00%
Unemployment Insurance	0.00%
Disability Insurance	0.16%
Workers' Compensation	0.11%
Pension/Retirement	11.73%
Total Fringe Benefits	38.51%

BUDGET NARRATIVE/JUSTIFICATION ATTACHMENT
FORM B-3
OTHER THAN PERSONAL SERVICES (OTPS)

Contractor: Warren County Health Services
Contract Period: April 1, 2008 - March 31, 2009
Contract No: C-020637

OTHER THAN PERSONAL SERVICES

Item	Cost	Description
PB Testing	$300	To cover costs of Lead Testing. Current Contract with Glens Falls Hospital to provide service
Educational Supplies	$200	To cover any Informational supplies needed to promote Lead testing
Postage	$550	To cover any postage associated with the Lead Poisioning Prevention Grant
Conference/Training	$750	To cover any staff training associated with the Lead Grant, including travel costs
Repair/Maintenance of equipment	$100	To cover any equipment maintenance costs
Office Supplies	$300	To cover general office supplies needed by the Lead program.
Total	$2,200	

Appendix D

CHILDHOOD LEAD POISIONING PREVENTION PROGRAM (CLPPP) WORKPLAN
April 1, 2008 - March 31, 2009
Warren County Health Services
Contract No.: C-020637

I. GENERAL CONTRACTOR INFORMATION

Corporate Name and Address: Warren County Health Services
1340 State Route 9
Lake George, NY 12845

Federal Employer ID#: 14-6002576
Charities Registration No., if applicable: NA

DIRECTORof CLPPP (person responsible for managing the program responsibilities):

Name: Patricia Auer Title: Director of Public Health
Address: Same as above
Exact E-mail address: auerp@co.warren.ny.us
Phone Number: (518) 761-6580
Fax Number: (518) 761-6422

ALTERNATE PROGRAM CONTACT IF DIRECTOR IS ABSENT:

Name: Ginelle Jones Title: Assistant Director
Address (if different from above): Same as above
Phone Number: (518) 761-6580
Fax Number: (518) 761-6422

OUTREACH EDUCATION CONTACT (person responsible for the educational component of the program):

Name: Patricia Belden Title: Public Health Nurse
Address (if different from above): Same as above
Phone Number: (518) 761-6580
Fax Number: (518) 761-6422

FISCAL CONTACT (person responsible for managing the fiscal component of the program):

Name: Tawn Driscoll Title: Fiscal Manager
Address: same as above
Exact E-mail address: driscollt@co.warren.ny.us
Phone Number: (518) 761-6580
Fax Number: (518) 761-6422

II. SUMMARY STATEMENT

Grant funds will be used to support and enhance local efforts to reduce the prevalence of elevated blood lead levels in children through the implementation of a comprehensive program of primary and secondary prevention, which includes: public and professional outreach and education, and in collaboration with local primary care providers; screening, diagnostic evaluation, medical management and environmental interventions.

SCHEDULE "A"

AUTHORIZATION TO ATTEND MEETING OR CONVENTION

Check one:

☒ In-State (needs Supervisory Committee authorization)

☐ Out-Of State (needs Board resolution)

The Health Services Committee hereby authorizes Patricia Belden, Communicable Disease Coordinator
(Supervisory Committee) (Employee Name)

to attend New York State APIC Coordinating Council Basic Training Course for the Novice Infection Prevention Practitioner
(Name of meeting or organization)

at The Holiday Inn Wolf Rd. Albany, NY
(Address)

on Monday May 12-Friday May 16, 2008. Mode of transportation to be used County vehicle
(Dates) (County Vehicle or Mass Transportation)

If the mode of transportation is **not** a county vehicle or mass transportation, please explain:

Proper documentation must be attached when submitting for approval.
(Please check documents attached)

☒ Notice of meeting or convention including cost.

For Overnight Travel

☐ Room rate $ N/A GSA* Rate $ N/A

☐ Meal costs - GSA*per diem rate $ N/A

*www.gsa.gov

Date: March 14, 2008 Patricia [signature]
Department Head Signature

Date: [signature]
Committee Chairman Signature

Please refer to the Warren County Travel Policy and County Vehicle Use Regulations for general policy guidelines.

****

Please check to request a fleet vehicle.

☐ **REQUEST FOR USE OF FLEET VEHICLE**

****

Filing Instructions:

1. Original with voucher to Auditor.
2. Copy to Frank Morehouse if fleet vehicle is needed.
3. Copy to Clerk of the Board with Resolution Request form if out-of-state travel.
4. Copy to Purchasing with Purchase Order, if required.
5. Copy to Commissioner of Administrative and Fiscal Services if credit card will be used.

May 12th through 16th 2008

New York State APIC Coordinating Council

NYSACC The Association for Professionals in Infection Control and Epidemiology Inc

Basic Training Course for the Novice Infection Prevention Practitioner

Mail Program Registration Form with Registration Fee

Please Print clearly or Type your name as you wish it to appear on your Name tag and Certificate of Attendance

Print Name: Patricia Belden

Work Title: Communicable Disease Coordinator

Facility: Warren County Public Health

Mailing Address: 1340 State Route 9

Town/City: Lake George Zip Code: 12845

Email Address: beldenp@co.warren.ny.us

Practice Setting: Please check as many as apply.

- ☐ Acute Care
- ☐ Long Term Care
- ☐ Ambulatory Care
- ☐ Behavioral Health Care
- ☒ Other Public Health

Facility Size:

- ☐ Under 50 beds
- ☐ 50-100 beds
- ☐ 100-200 beds
- ☐ 200-300 beds
- ☐ Over 300 beds
- ☐ Other _____

Educational Background: Please check as many as apply.

- ☐ LPN
- ☐ Diploma RN
- ☐ Associate RN
- ☒ Bachelor's degree
  - ☒ Nursing
  - ☐ Other _____
- ☐ Masters Degree/Field: _____
- ☐ Other _____

Please list any special Dietary Restrictions: ∅

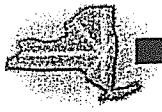
I attest that I have 1) the position of an Infection Prevention / Control coordinator / practitioner in my organization, 2) been in this role for at least 3 months prior to the program, 3) not attended a basic infection prevention or ICE 1 training course.

Patricia Belden Signature of attendee (required)

REGISTRATION FEE: $150.00 non refundable Payment MUST accompany registration.

Checks Payable to: ECMC (Erie County Medical Center) NO VOUCHERS ACCEPTED

Mail Completed Registration Form with Payment to:
Margaret Brinn, NYSACC Registrant
2484 Bath Road
Penn Yan, NY 14527



New York State APIC Coordinating Council

NYSACC

The Association for Professionals in Infection Control and Epidemiology Inc

February 28, 2008

Dear Healthcare Administrator:

The New York State Association for Professionals in Infection Control Coordinating Council (NYSACC) is pleased to announce a Basic Training Course for the Novice Infection Prevention Practitioner.

This program is designed to provide the fundamentals of Infection Surveillance, Prevention and Control. It will emphasize the role and responsibilities of the Infection Control Practitioner in New York State. The program curriculum will include how to design an infection surveillance, prevention and control program specific to the population the organization serves. An experienced faculty team will provide education and incorporate real life experiences.

The program is a 5 day comprehensive basic training course during the week of May 12-16, 2008. It will be held at the Holiday Inn on Wolf Road, in Albany NY.

The cost for the program is being funded by the New York State Department of Health, Hospital-Acquired Infection Reporting Program. As a result of this support, the cost of the program has been kept to a minimum. Each participant will be asked to pay a non-refundable registration fee of $150.00 which will be used to cover breaks, lunch, and materials. Participants will be responsible for their own hotel accommodations and travel to and from the conference. The cost of registration for similar preparation courses can range from $425 to $1000.

We are asking that each program participant meet the following eligibility requirements. He/she:

1. Has responsibility for infection prevention and surveillance.
2. Has been in his/her role for at least 3 months.
3. Has not attended a basic training course or an ICE 1 program.

This program is the ideal way to prepare an individual to perform the duties and responsibilities required by his/her position in a New York State ambulatory, alternative, acute, or long-term care facility.

Enrollment is limited to the first 150 registrants. For further information please contact the program registrar, Marge Brinn at marg_brinn@msn.com. Registration will close on April 18, 2008.

Christine Gagnon, NYSACC President

SCHEDULE "A"

AUTHORIZATION TO ATTEND MEETING OR CONVENTION

Check one:

☒ In-State (needs Supervisory Committee authorization)

☐ Out-Of State (needs Board resolution)

The Health Services Committee hereby authorizes Patricia Belden, Communicable Disease Coordinator
(Supervisory Committee) (Employee Name)

to attend New York State APIC Coordinating Council Basic Training Course for the Novice Infection Prevention Practitioner
(Name of meeting or organization)

at The Holiday Inn Wolf Rd. Albany, NY
(Address)

on Monday May 12-Friday May 16, 2008. Mode of transportation to be used County vehicle
(Dates) (County Vehicle or Mass Transportation)

If the mode of transportation is **not** a county vehicle or mass transportation, please explain:

_____

Proper documentation must be attached when submitting for approval.
(Please check documents attached)

☒ Notice of meeting or convention including cost.

For Overnight Travel

☐ Room rate $ _____ GSA* Rate $ _____

☐ Meal costs - GSA*per diem rate $ _____

*www.gsa.gov

Date: March 14, 2008 _____
Department Head Signature

Date: _____ _____
Committee Chairman Signature

Please refer to the Warren County Travel Policy and County Vehicle Use Regulations for general policy guidelines.

****

Please check to request a fleet vehicle.

☐ **REQUEST FOR USE OF FLEET VEHICLE**

****

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May 12th through 16th 2008

New York State APIC Coordinating Council

NYSACC The Association for Professionals in Infection Control and Epidemiology Inc

Basic Training Course for the Novice Infection Prevention Practitioner

Mail Program Registration Form with Registration Fee

Please Print clearly or Type your name as you wish it to appear on your Name tag and Certificate of Attendance

Print Name: Patricia Belden

Work Title: Communicable Disease Coordinator

Facility: Warren County Public Health

Mailing Address: 1340 State Route 9

Town/City: Lake George **Zip Code:** 12845

Email Address: beldenp@co.warren.ny.us

Practice Setting: Please check as many as apply.

- ☐ Acute Care
- ☐ Long Term Care
- ☐ Ambulatory Care
- ☐ Behavioral Health Care
- ☒ Other Public Health

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- ☐ Under 50 beds
- ☐ 50-100 beds
- ☐ 100-200 beds
- ☐ 200-300 beds
- ☐ Over 300 beds
- ☐ Other _____

Educational Background: Please check as many as apply.

- ☐ LPN
- ☐ Diploma RN
- ☐ Associate RN
- ☒ Bachelor's degree
  - ☒ Nursing
  - ☐ Other _____
- ☐ Masters Degree/Field: _____
- ☐ Other _____

Please list any special Dietary Restrictions: Ø

I attest that I have 1) the position of an Infection Prevention / Control coordinator / practitioner in my organization, 2) been in this role for at least 3 months prior to the program, 3) not attended a basic infection prevention or ICE 1 training course.

Patricia Belden **Signature of attendee (required)**

REGISTRATION FEE: $150.00 non refundable Payment MUST accompany registration,

Checks Payable to: ECMC (Erie County Medical Center) NO VOUCHERS ACCEPTED

Mail Completed Registration Form with Payment to:
Margaret Brinn, NYSACC Registrant
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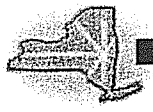
Penn Yan, NY 14527



New York State APIC Coordinating Council

NYSACC

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3. Has not attended a basic training course or an ICE 1 program.

This program is the ideal way to prepare an individual to perform the duties and responsibilities required by his/her position in a New York State ambulatory, alternative, acute, or long-term care facility.

Enrollment is limited to the first 150 registrants. For further information please contact the program registrar, Marge Brinn at marg_brinn@msn.com. Registration will close on April 18, 2008.

Christine Gagnon, NYSACC President

RESOLUTION REQUEST FORM NO. 3

Request for *New* Contract

DEPARTMENT NAME: Health Services

DATE: March 28, 2008

(a) Is this a Result of a Bid or Request for Proposal? No

(b) Purpose of Contract: To authorize a contract agreement with Adam Willis to provide physical therapy services

(c) Name of Contractor: Adam Willis

(d) Address of Contractor: 574 Lower Wright Street, Hudson Falls, NY 12839

(e) Contractor's Contact Person and Telephone Number: Adam Willis, 225-5049

(f) Has or will the Contract be provided, if so, please attach: Use therapist contract

(g) Commencement Date of Contract: 4/21/08

(h) Termination Date of Contract: 30 days written notice by either party

(i) Payment Provisions:i) lump sum amount at agreed upon established per individual visit or meeting rate upon receipt of required documentation for each visit at following rates: Region 1: evals $55, revisits $53; Region 1: evals $60, revisits $60; OASIS: $15 per patient; Meetings: $40

ii) hourly rate amount
iii) total amount not to exceed
iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc. Bi-monthly

(j) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount: **OR** Capital Project **OR** Capital Reserve Project Number, and Title, and Amount: A4010.10.470 Health Services, A4016.10.470 Long Term Care

Print Date: 03/14/08

CNA

HEALTHCARE PROVIDERS SERVICE ORGANIZATION PURCHASING GROUP CERTIFICATE OF INSURANCE OCCURRENCE POLICY FORM

Producer	Branch	Prefix	Policy Number	Policy Period
018098	970	HPG	0312045639	from: 12:01 AM Standard Time on: 03/12/08 to: 12:01 AM Standard Time on: 03/12/09

Named Insured and Address:

Adam M Willis
574 Lower Wright St
Hudson Falls, NY 12839-2681

Medical Specialty: Physical Therapist
Code: 80995

Program Administrator:

Healthcare Providers Service Organization
159 East County Line Road
Hatboro, PA 19040-1218

Insurance Provided by:

American Casualty Company of Reading, Pennsylvania
333 S. Wabash Avenue, Chicago, IL 60604

A. PROFESSIONAL LIABILITY

COVERAGE PARTS	LIMITS OF LIABILITY			
Professional Liability (PL)	$ 1,000,000	each claim	$ 3,000,000	aggregate
Good Samaritan Liability	included above			
Personal Injury Liability	included above			
Malplacement Liability	included above			

B. COVERAGE EXTENSIONS:

License Protection	$ 10,000	per proceeding	$ 25,000	aggregate
Defendant Expense Benefit			$ 10,000	aggregate
Deposition Representation	$ 2,500	per deposition	$ 5,000	aggregate
Assault	$ 10,000	per incident	$ 25,000	aggregate
Medical Payments	$ 2,000	per person	$ 100,000	aggregate
First Aid			$ 2,500	aggregate
Damage to Property of Others	$ 500	per incident	$ 10,000	aggregate

C. WORKPLACE LIABILITY

Coverage part C. Workplace Liability does not apply if Coverage part D. General Liability is made part of this policy.

Workplace Liability	included in A. PL limit shown above		
Fire & Water Legal Liability	included in A. PL limit shown above subject to $150,000 sub-limit		
Personal Liability		$1,000,000	aggregate

D. GENERAL LIABILITY

Coverage part D. General Liability does not apply if Coverage part C. Workplace Liability is made part of this policy.

General Liability (GL)	none	none
Hired Auto & Non Owned Auto	none	
Fire & Water Legal Liability	none	none
Personal Liability		none

Total Premium: $ 278.00

QUESTIONS? CALL: 1-800-982-9491

Policy forms and endorsements attached at inception:

G-121500-C G-121503-C G-121501-C G-145184-A
G-147292-A G-144872-A G-123813-C31 G-123814-D31 G-123846-D31
G-123819-D31

Master Policy # 188711433

Keep this document in a safe place. It and proof of payment are evidence of your insurance coverage.

Chairman of the Board

Secretary

G-141241-A (07/2001)

Coverage Change Date:

Endorsement Change Date:

RESOLUTION REQUEST FORM NO. 12

Request to Fill Vacant Position*

***(Please Note: A Resolution IS NOT REQUIRED for approval IF the vacant position is funded in the Warren County Salary Budget. However, the request must be approved by the Personnel Committee BEFORE the position is filled as well as the Finance Committee if new dollars are involved.**

A Resolution IS REQUIRED if the vacant position is NOT FUNDED in the Warren County Salary Budget.)

DEPARTMENT NAME: Health Services

DATE: March 28, 2008

(a) Title of Vacant Position to be Filled: Community Health Nurse

(b) Date position became vacant: 3/9/08

(c) Do You Anticipate Filling the Position In-House? No
If Yes, List Employee Number:

(d) Annual Salary of Position (and Grade if Applicable):* $40,647.00, Grade 20
*(This should be the Base Salary for the position if it is being filled by a **new** employee, **or** the salary, **including longevities**, for any **existing** employee who is filling the position.

(e) Effective Date of Filling Position:* As soon as possible
*Please do not backdate unless the purpose is to correct an error.

(f) Where are Funds in the Budget for this Position? (List budget code (with title), object code (with title), and amount): A4010.10.110 Salaries Health Services

(g) Does the Vacant Position Show a Salary in the Budget? Yes

(h) Will Lower Level Position be Vacated as a Result of Filling this Vacancy? If yes, is there a Request to Fill that Position also? No

(i) If Yes, will it be Filled In-House?
If Yes, List Current Title and Employee No.:

(j) Salary of Lower Level Position:*
*See notes under Item No. (c) concerning how the salary should be listed.

(k) Effective Date of Filling Lower Level Position:

(l) Is this a mandated position? If so, please explain: Not mandatory but necessary in order to cover patient service demands

(m) Is there expected revenue from this position? If so, please explain: Yes, nursing services are billable services

Schedule "A"

NOTICE OF INTENT TO FILL VACANT POSITION

This notice of intent is filed whenever a department head plans to fill an *existing* funded position in their budget that is vacated due to a retirement, resignation or termination. This notice may not be used for requests to create a *new* position. *For complete instructions on the procedure to be followed, see the reverse of this form.*

DEPARTMENT HEAD COMPLETES THIS SECTION

Department Health Services
Title of Position Community Health Nurse Base salary $ 40,647
Budget code and title A4010-10-110 Health Services
This position is vacate due to: ☐ Retirement ☒ Resignation ☐ Termination
Employee No. 10384
* please note below information

COMMISSIONER OF ADMINISTRATIVE & FISCAL SERVICES COMPLETES THIS SECTION

Name of Committee Health Services Date 3-24-08
☒ The Commissioner has no objection to the filling of the vacancy.
☐ The Commissioner objects to the filling of the vacancy.

Commissioner Signature H. D. Payne

SUPERVISORY COMMITTEE COMPLETES THIS SECTION

Name of Committee Health Services Date 3/28/08
☐ The committee has no objection to the filling of the vacancy.
☐ The committee objects to the filling of the vacancy and will be sending a resolution to the full board to have the position removed from the budget.

Ranking Committee Member Signature _____

PERSONNEL COMMITTEE COMPLETES THIS SECTION

Date _____
☐ The Personnel Committee has no objection to the filling of the vacancy.
☐ The Personnel Committee objects to the filling of the vacancy and will be sending a resolution to the full board to have the position removed from the budget.

Ranking Committee Member Signature _____

December 2006

* per previous discussion, new nurse will be placed in grade according to education and experience level and table of organization will be amended accordingly.

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: March 28, 2008

(a) Purpose of Contract Change: To authorize continuation of agreement with Outcome Concept Systems Inc. to allow continued receipt of Benchmark Business Intelligence (BBI) and Electronic Performance Consultant (EPIC) in order to submit Medicare bills and extract necessary data

(b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: 250/2007

(c) Name of Contractor: Outcome Concept Systems Inc.

(d) Address of Contractor: 1818 East Mercer Street, Seattle, WA 98112

(e) Contractor's Contact Person and Telephone Number: Jodi Gile, 206-325-3396

(f) Commencement Date of Amendment: 4/1/08

(g) Termination Date of Extension: 30 days

(h) Payment Provisions:

- i) lump sum amount $5,000.00
- ii) hourly rate amount
- iii) total amount not to exceed
- iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.

(i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount: A4010.428 Data Processing

OCS
LEADING HEALTHCARE INSIGHT

Outcome concepts systems

V 13894

NAYELI E. GURDIAN
Contract Administrator
1818 East Mercer Street
Seattle, WA 98112
p 206.325.3396 | f 206.720.6018 | naygur@ocsys.com

g Board of Supervisors

TION NO. 250 OF 2007

Supervisors Mason, Sheehan, Haskell, F. Thomas,

AMENDING AGREEMENT WITH OUTCOME CONCEPT SYSTEMS, INC. TO INCLUDE BENCHMARK BUSINESS INTELLIGENCE (BBI)AND ELECTRONIC PERFORMANCE IMPROVEMENT CONSULTANT (EPIC) SERVICES - HEALTH SERVICES DEPARTMENT

WHEREAS, Resolution No. 603 of 2006 authorized the continuation of the agreement with Outcome Concept Systems, Inc., ("Outcome") for OASIS data collection and submission software program and support services, for the sum of Five Thousand Five Hundred Dollars ($5,500) per year, and

WHEREAS, the Director of Health Services has advised that the portion of the agreement concerning Benchmark Business Intelligence (BBI) and Electronic Performance Improvement Consultant (EPIC) Services was not renewed, in anticipation of moving into a point of care system that would involve another type of billing system, as opposed to the system provided by Outcome; however, it is now unknown when the new point of care system will come on line and, in the meantime, Medicare bills cannot be submitted, nor can necessary data be extracted, without the reinstatement of the BBI and EPIC Services, now, therefore, be it

RESOLVED, that the agreement with Outcome Concept Systems, Inc., be, and hereby is, amended to include Benchmark Business Intelligence and Electronic Performance Improvement Consultant Services, at an additional cost of Five Thousand Dollars ($5,000), and the Chairman of the Board of Supervisors be, and hereby is, authorized to execute an agreement or such other paperwork that would fulfill the terms of this resolution, in a form approved by the County Attorney.

DeCesare, Diane

From: Pacyna, Julie
Sent: Thursday, March 13, 2008 1:43 PM
To: DeCesare, Diane
Subject: PO 657

Diane,

The resolution you refer to on the above-referenced purchase order does not specifically state that the $5,000 fee is per year. It appears to only authorize one payment of $5,000. I posed the question to Diana in the County Attorney's Office and she's going to pull the back-up and let me know if they just made a mistake in the reso.

Julie A. Pacyna
Warren County Purchasing Agent
1340 State Route 9
Lake George, NY 12845
Ph: 518-761-6538
Fax: 518-761-6395

V13844

OCS
LEADING HEALTHCARE INSIGHT

1818 East Mercer St.
Seattle, WA 98112

206.325.3396 (P)
206.720.6018 (F)

www.ocsys.com

A4010.428

Invoice

PO 0657

DATE	INVOICE #
3/5/2008	IVC02025

BILL TO

Warren County Health Services
1340 state Route 9
Lake George NY 12845

Due Date	Terms
4/4/2008	Net 30
P.O. NO.	**Account #**
	6154

DESCRIPTION	QTY	RATE	AMOUNT
BBI Elite - Benchmark Business Intelligence Elite Browser based tool with ability to generate immediate condition - specific benchmark analysis	1.00	$2,500.00	$2,500.00
EPIC - Electronic Performance Improvement Consultant to guide you through your entire OBQI Process	1.00	$2,500.00	$2,500.00

RECEIVED
MAR 10 2008
WARREN COUNTY
HEALTH SERVICES

To pay by Credit Card, please fill out the information below and fax back to the OCS Finance Department at 206.720.6018

Visa/Mastercard No. _____

Expiration Date _____

Cardholder Name _____

Signature _____

Subtotal	$5,000.00
Sales Tax	$0.00
Misc	$0.00
Balance Due	$5,000.00

RESOLUTION REQUEST FORM NO. 5

Request to Apply for a Grant Application and Grant Agreement

DEPARTMENT NAME: Health Services

DATE: March 28, 2008

(a) Purpose of Grant: To obtain nursing education in preparation for possible development of a travel clinic at Health Services

(b) Name of Grantor: Sanofi Pasteur, Inc.

(c) Address of Grantor: 111 Washington Avenue, Scranton, PA 18503

(d) Grantor's Contact Person and Telephone Number: Robert Hettes, 570-496-6764 or 570-780-2352

(e) Has or Will the Grant Application or Grant Agreement be provided, if so, Please Attach? n/a

(f) Effective Date of Grant: one-time grant amount

(g) Termination Date of Grant: n/a

(h) Total Dollar Amount Involved (not to exceed): $1500.00, already received

(i) Deadline to Submit Grant Application and/or Grant Agreement: n/a

(j) Is a Budget amendment required? No If yes, also complete and submit Form No. 7.

(k) Are the funds to go into a Capital Project or Capital Reserve Project? No If yes, also complete and submit Form No. 8 or Form No. 9, as applicable.

(l) Is a Local Share Required? No If Yes, Where are the Funds? List Budget Code (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount: Preventive Program Disease Control Immunization Revenue A4018.0030.1613; Preventive Program Disease Control Contract Expense A4018.0030.470

Sanofi Pasteur Inc.

sanofi pasteur
The vaccines business of sanofi-aventis Group

Check Number

520348

Stub 1 of 1

PAYMENT ADVICE

We have settled the items listed below with the enclosed check for payment 520348, subject to the goods and services supplied and the invoice therefore being in order.

INVOICE NUMBER	INVOICE DATE	COMMENT	GROSS	DEDUCTIONS	AMOUNT PAID
GRANT 04/01/08	02/29/2008		1,500.00	0.00	1,500.00

DETACH BEFORE DEPOSITING

THIS IS WATERMARKED PAPER - DO NOT ACCEPT WITHOUT NOTING WATERMARK - HOLD TO LIGHT TO VERIFY WATERMARK

Sanofi Pasteur Inc.

31031354

sanofi pasteur
The vaccines business of sanofi-aventis Group

JPMorgan Chase Bank N.A.
Syracuse, NY 13206

50-937
213

NUMBER 520348
VOID AFTER 90 DAYS

DATE	AMOUNT
03/18/2008	$*********1,500.00

Two Signatures Required For Amounts Over $25,000.00

PAY
ONE THOUSAND FIVE HUNDRED DOLLARS ***********
TO THE ORDER OF

WARREN COUNTY PUBLIC HEALTH
1340 STATE ROUTE 9
LAKE GEORGE NY 12845

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

⑈000520348⑈ ⑆021309379⑆601866460⑈

Six Flags Great Escape Lodge and Waterpark GI Illness Outbreak
Daily Summary, March 27, 2008

Summary to Date: 463 persons from 32 counties in New York State, seven other states, and Canada have reported gastrointestinal illness. There have been no additional hospitalizations. Onsets range from March 3 to March 27. The number of cases, by onset, peaked on March 16 with a total of 96 cases. There were three cases with onsets on March 24, two on March 25, and one on March 27. There are no new laboratory results. The call center has received 556 calls as of noon today; 48 calls were received between noon March 26 and noon March 27.

Surveillance Updates:

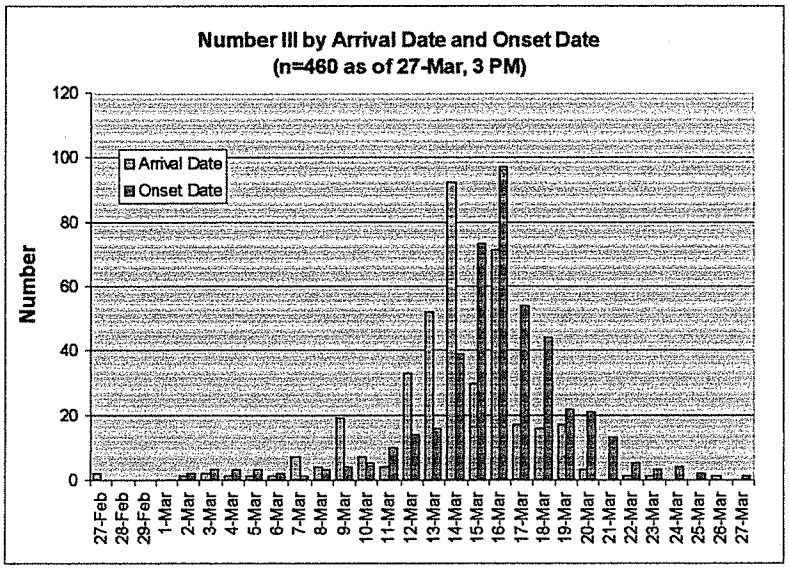
- The following surveillance updates were provided by facility staff and Dr. Marc Tack.

  - Employee surveillance:
    Employee surveillance continues daily. One additional employee reported illness onset on 3/27.

  - Guest surveillance among persons currently at the facility:
    No additional guest illnesses reported.

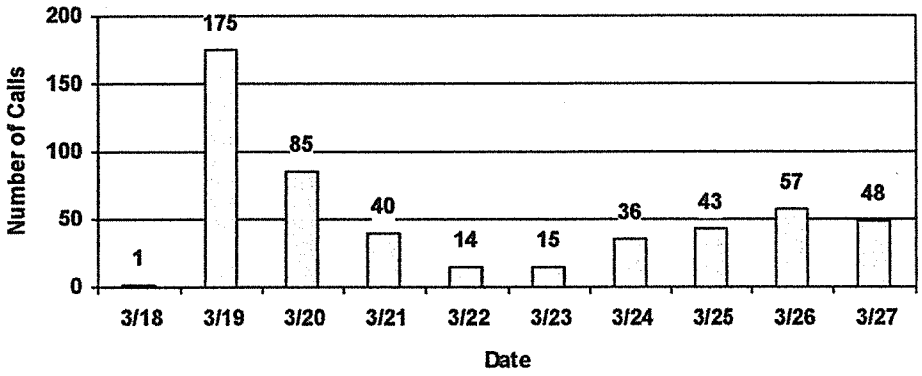
  - Guest surveillance among persons who have recently checked out:
    The facility continues to contact persons who recently departed to assess if there is ongoing illness. According to Dr. Tack, 3 of 42 calls to checkouts reported illness.

Epi Curve: Reports of illness now resolved continues to increase. Reports with recent illness onset continues to trail off. Please note that numbers per day have changed with data clean-up (e.g., exclusion of those not meeting case criteria), but the overall picture has not changed significantly in the past few days.



Note: excludes 3 outlying illness onsets in January and early February. 76 arrival dates and 16 onset dates are unknown.

Call Center:
As of noon March 27, 556 calls have been received by the call center. Among the 48 calls received today, 17 callers reported illness; one caller had onset on each of 3/24, 3/25, and 3/27. We will be following up to verify dates.



Laboratory Updates:

- No new laboratory results.
- Two of eight specimens have been tested, one is preliminarily positive for norovirus.

- **Media Updates:** Media coverage continues.

Number Ill by County
(n=431 as of 3/26/08, 3 PM)

Albany	36
Clinton	2
Columbia	5
Cortland	1
Delaware	4
Dutchess	9
Erie	1
Essex	5
Fulton	12
Greene	4
Hamilton	4
Herkimer	2
Madison	1
Monroe	2
Montgomery	7
Nassau	3
NYC	2
Oneida	2
Onondaga	5
Orange	6
Otsego	7
Putnam	2
Rensselaer	39
Rockland	1
Saratoga	65
Schenectady	21
Schoharie	2
St.Lawrence	1
Suffolk	3
Ulster	35
Warren	57
Washington	16
Westchester	1
Out of State	65
Grand Total	428

463 as of 3/27

Auer, Pat

From: Anita M. Gabalski [amg02@health.state.ny.us]
Sent: Thursday, March 27, 2008 4:11 PM
To: Auer, Pat
Subject: 6 Flags Update

Pat-

My inspector just called me from the resort. He said that he was told that there wer two employees who were ill this morning and two who were ill for the second shift. Non of them are working. They have no new repots of patron illness today. Even though the Tall Tales restaurant is open, they close it daily from 2:30 to 4:00pm for cleaning and then reopen it for dinner. Nothing else unusual to report.

Anita M. Gabalski
Glens Falls District Office
77 Mohican Street
Glens Falls, NY 12801
(518) 793-3893

Communicable Disease
New York State Department of Health

Norwalk Virus Infection (calicivirus)

What is Norwalk virus infection?
Norwalk virus infection is a gastrointestinal illness that occurs sporadically or in outbreaks. The virus was first identified during a gastroenteritis outbreak in Norwalk, Ohio, in 1972. There are a number of strains of Norwalk virus which are also referred to as calicivirus.

Who gets Norwalk virus infection?
Anyone can become infected. It only occurs in humans and is found worldwide.

How is it spread?
Norwalk viruses are spread by exposure to infected people or contaminated food and water. The virus is passed in stool and vomit. Outbreaks have been linked to sick food handlers, contaminated shellfish or water contaminated with sewage. It is generally spread from person to person by direct contact, but some medical reports suggest that the virus can spread through the air during vomiting.

What are the symptoms?
Although the virus is easy to spread, serious illness rarely occurs. The most common symptoms include nausea, vomiting and stomach cramps. Diarrhea may occasionally accompany vomiting. Fever is usually low grade or absent. Infected people generally recover in one to two days.

How soon after exposure do symptoms appear?
The incubation period is one to two days.

What is the treatment for Norwalk virus infection?
No specific treatment is available. Persons who become dehydrated might need to be rehydrated by taking liquids by mouth. Occasionally patients may need to be hospitalized to receive intravenous fluids.

How can Norwalk virus infection be prevented?
The following recommendations may reduce the risk of acquiring or spreading the infection:

- Wash hands thoroughly after each toilet visit and before preparing food.
- People who experience nausea, vomiting or diarrhea should not attend school or work and should not handle food for others while ill.
- Avoid drinking untreated water.
- Cook shellfish thoroughly before eating.

Revised: May 2004

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: 3/28/2008

(a) Purpose of Contract Change: To authorize a technical amendment to Delta Healthcare Technologies LLC to provide for a 5 year contract at the conclusion of which the agreement between the parties will be renewed and may at the County's option be renewed for an additional period of 5 years. The county will reserve the right to terminate the agreement at the end of each one year term.

(b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: 2/14/2008

(c) Name of Contractor: Delta Healthcare Technologies LLC

(d) Address of Contractor: 400 Lakemont Park Boulevard, Altoona, PA 16602

(e) Contractor's Contact Person and Telephone Number: Joe Fockler (814) 317-7051

(f) Commencement Date of Amendment: 4/1/08

(g) Termination Date of Amendment: (See amendment detail info)

(h) Payment Provisions: $540,475 per contract specifications

- i) lump sum amount
- ii) hourly rate amount
- iii) total amount not to exceed
- iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.

(i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount:
Capital Project No: H282-9550 280 Point of Care

Warren County Board of Supervisors

RESOLUTION NO. 214 OF 2008

Resolution introduced by Supervisors Stec, Belden, O'Connor, Bentley, Tessier, Champagne, VanNess, Kenny and Merlino

ACCEPTING PROPOSAL AND AUTHORIZING AGREEMENT WITH DELTA HEALTH TECHNOLOGIES, LLC FOR POINT OF CARE SOFTWARE SYSTEM FOR THE WARREN COUNTY HEALTH SERVICES DEPARTMENT (WC 40-08) - HEALTH SERVICES DEPARTMENT

WHEREAS, the Purchasing Agent has advertised for Request for Proposals for a Point of Care Software System for the Warren County Health Services Department (WC 40-08), and

WHEREAS, the Director of Public Health/Patient Services has issued correspondence recommending award of the agreement to Delta Health Technologies, LLC, with the lowest responsible Proposal, now, therefore, be it

RESOLVED, that Warren County enter into an agreement with Delta Health Technologies, LLC, 400 Lakemont Park Boulevard, Altoona, Pennsylvania 16602, pursuant to the terms and provisions of the Specifications (WC 40-08) and Proposal, for a total cost of Five Hundred Forty Thousand Four Hundred Seventy-Five Dollars ($540,475), for a term commencing on April 1, 2008 and terminating upon sixty (60) days notice by either party, and the Chairman of the Board of Supervisors be, and hereby is, authorized to execute the agreement in the form approved by the County Attorney, and be it further

RESOLVED, that the funds for said agreement shall be expended from Capital Project No. H282.9550 280 - Point of Care.

SCHEDULE "A"

AUTHORIZATION TO ATTEND MEETING OR CONVENTION

Check one:

☒ In-State (needs Supervisory Committee authorization)

☐ Out-Of State (needs Board resolution)

The Westmount Health Facility (Supervisory Committee) hereby authorizes Sandra Smith (Employee Name)

to attend Medicare Management and the Skilled Nursing Facility seminare (Name of meeting or organization)

at Holiday Inn Wolf Road Albany, New York (Address)

on 5/13/2008 (Dates). Mode of transportation to be used Westmount Health County Vehicle (County Vehicle or Mass Transportation)

If the mode of transportation is **not** a county vehicle or mass transportation, please explain:

_____

Proper documentation must be attached when submitting for approval.

(Please check documents attached)

☒ Notice of meeting or convention including cost.

For Overnight Travel

☐ Room rate $ _____ GSA* Rate $ _____

☐ Meal costs - GSA*per diem rate $ _____

*www.gsa.gov

Date: March 28, 2008 _____ Department Head Signature

Date: March 28, 2008 _____ Committee Chairman Signature

Please refer to the Warren County Travel Policy and County Vehicle Use Regulations for general policy guidelines.

****

Please check to request a fleet vehicle.

☐ **REQUEST FOR USE OF FLEET VEHICLE**

****

Filing Instructions:

1. Original with voucher to Auditor.
2. Copy to Frank Morehouse if fleet vehicle is needed.
3. Copy to Clerk of the Board with Resolution Request form if out-of-state travel.
4. Copy to Purchasing with Purchase Order, if required.
5. Copy to Commissioner of Administrative and Fiscal Services if credit card will be used.

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☐ Out-Of State (needs Board resolution)

The Westmount Health Facility (Supervisory Committee) hereby authorizes BARBARA TAGGART (Employee Name)

to attend NYAHSA SPRING TRAINING INSTITUTE AND EXHIBITION (Name of meeting or organization)

at THE SARATOGA HILTON HOTEL & CONFERENCE CENTER: SARATOGA SPRINGS, NY (Address)

on 05/19-22/08 (Dates). Mode of transportation to be used WESTMOUNT COUNTY VEHICLE (County Vehicle or Mass Transportation)

If the mode of transportation is **not** a county vehicle or mass transportation, please explain:

_____

Proper documentation must be attached when submitting for approval.

(Please check documents attached)

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For Overnight Travel

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☐ Meal costs - GSA*per diem rate $ _____

*www.gsa.gov

Date: 03/28/08 _____ Department Head Signature

Date: 03/28/08 _____ Committee Chairman Signature

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