

HEALTH SERVICES COMMITTEE
WESTMOUNT HEALTH FACILITY

FRIDAY, JANUARY 22, 2009
MUNICIPAL BUILDING BOARD ROOM
9:30AM

1. Resolution request for a new contract with Mahoney Notify-Plus, Inc. Pgs. 1-4
2. Request permission to fill vacant position – Leisure Time Activities Aide. Pg. 5
3. Resolution request for new contract with Visiting Nurse Association of Albany Home Care Corporation. Pg. 6
4. Amend contract with Ruffo, Tabora, Mainello & McKay, PC, to include additional expenditures regarding physician billing. Pg. 7
5. Request resolution to amend County Budget for 2010 contracted services appropriations by amending the unrestricted fund balance. (\$3,000.00). Pg. 8
6. Request permission to reclassify ADON position to MDS Coordinator. \$48,700.00. Pg. 9
7. Staffing Report. Pg. 10
8. Overtime Report. Pg. 11

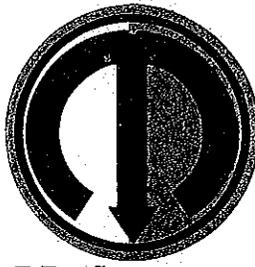
RESOLUTION REQUEST FORM NO. 3

Request for New Contract

DEPARTMENT NAME: WESTMOUNT HEALTH FACILITY

DATE: January 22, 2010

- (a) Is this a Result of a Bid or Request for Proposal? No
- (b) Purpose of Contract: To provide Semi-Annual Test and Inspections of Fire Alarm, Sprinkler Alarm and Security Alarm for Westmount Health Facility for \$ 1,210.00 also to include additional Emergency Repair Coverage not to exceed \$1,000.00.
- (c) Name of Contractor: Mahoney Notify-Plus Inc.
- (d) Address of Contractor: PO Box 767, 15 Cooper Street, Glens Falls, NY 12801
- (e) Contractor's Contact Person and Telephone Number: Kevin Mahoney, 518 793-7788
- (f) Has or will the Contract be provided, if so, please attach: Yes
- (g) Commencement Date of Contract: March 1, 2010
- (h) Termination Date of Contract: February 28, 2011
- (i) Payment Provisions: i) lump sum amount
ii) hourly rate amount
iii) total amount not to exceed \$2,210.00/year
iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc. completion of annual inspection and/or emergency repair
- (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: EF.82200.6822 470 Plant Operation and Maintenance, Contracted Service \$19,000.00.



P.O. Box 767 - 15 Cooper St.
Glens Falls, NY 12801
518/793-7788
Fax 518/793-0602
www.mahoneyalarms.com

Mahoney
Notify-Plus Inc.
Alarms

Lake Placid, NY 12946
518/523-1600
Fax 518/793-0602

Plattsburgh, NY 12901
518/566-9147
Fax 518/793-0602

October 7, 2009

Mr. Frederick H. Monroe
County of Warren
Acting for and on behalf of
Westmount Infirmary
42 Gurney Lane
Queensbury, NY 12801

Dear Mr. Monroe:

This will advise your current contract(s) are due to expire and we have enclosed two copies of the renewal for same.

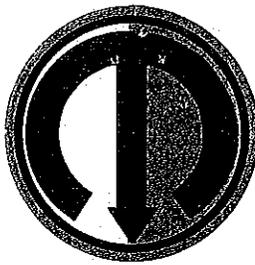
Should the enclosed meet with your approvals, **we ask that you execute both copies, returning one fully executed copy to our office for processing.** We are always interested in hearing from you regarding your questions, concerns and feedback.

Awaiting your advice, I remain

Sincerely,

Joan Nassivera

Joan Nassivera



P.O. Box 767 - 15 Cooper St.
Glens Falls, NY 12801
518/793-7788
Fax 518/793-0602
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October 7, 2009

County of Warren
Acting for and on behalf of
Westmount Infirmary
42 Gurney Lane
Queensbury, NY 12801

Att: Frederick H. Monroe

Semi-annual test and inspection of the **Fire alarm** system including:

- Smoke detectors
- Heat sensing thermostats
- Manual pull stations
- Bells and./or audible signal devices
- Above ceiling smoke detectors
- Door holder units
- Control panel including all batteries
- Circuits and complete test to the Warren Co. Sheriff's Office
- Extinguishers

Semi-annual inspection of the **Sprinkler alarm** system to include:

- Control valves
- Water pressure and switches
- Related sprinkler alarm devices

Semi-annual test and inspection of the **Security alarm** system including:

- Door annunciator panel
- Bell circuits
- Door contacts

Quotations made herein are with the provision that local on site maintenance personnel will assist with the inspections.

The term of this inspection agreement shall commence on **March 1, 2010** and **terminate on February 28, 2011**. The terms and conditions of the annexed Appendix A are incorporated into this Agreement as if more fully set forth herein.

This agreement does not include any repairs or replacement of the alarm devices. Technical services not covered under this agreement will be provided at a rate of \$82.50 per man hour, portal to portal for the first hour between the hours of 8:00am and 4:40pm Monday thru Friday and \$75.00 per man hour, portal to portal for each hour thereafter between the hours of 8:00am and 4:40pm Monday thru Friday. After hours, weekends and holiday service will be provided at a rate of \$120.00 per man hour, portal to portal for the first hour & \$112.50.00 per man hour portal/portal for each hour thereafter .

Devices requiring replacement will be invoiced at a 50% markup rate.

Westmount Infirmary will be invoiced at prevail wages when applicable as each situation arises. Customer is required to notify Mahoney Notify-Plus Inc., of any prevailing wage circumstances as each situation arises.

ANNUAL INSPECTION FEE \$1,210.00

County of Warren acting for and on behalf of
WESTMOUNT HEALTH FACILITY

AGREED AND UNDERSTOOD: _____
BY: _____

DATE: _____

AGREED AND UNDERSTOOD: *Kevin Mahoney*
Mahoney Notify-Plus Inc.

DATE: 10-7-09

Approved as to Form:

Warren County Attorney

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 Leisure Time Activity Aide

Base salary 14,034.00 & Shift Dif

Budget code and title EF.72600.400 130 Westmount, Activities Prog., LPN& Activites Dir Wages

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

Employee No. 10827

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 _____

RESOLUTION REQUEST FORM NO. 3

Request for New Contract

DEPARTMENT NAME: Westmount Health Facility

DATE: January 22, 2010

- (a) Is this a Result of a Bid or Request for Proposal? No
- (b) Purpose of Contract: Nursing Coverage in event of emergency
- (c) Name of Contractor: Visiting Nurse Association of Albany Home Care Corporation
- (d) Address of Contractor: 150 Broadway, Suite 310, Menands, NY 12204
- (e) Contractor's Contact Person and Telephone Number: Kenneth J. Mouney,
Director
- (f) Has or will the Contract be provided, if so, please attach: Yes
- (g) Commencement Date of Contract: 3/1/2010
- (h) Termination Date of Contract: Upon 30 days notice
- (i) Payment Provisions:
 - i) lump sum amount
 - ii) hourly rate amount Per Fee Schedule
 - iii) total amount not to exceed
 - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (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: EF.60200.6801 470 Westmount, Nursing-Nurses' Station, Contracted Services. \$1,000.00

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Existing Contract

DEPARTMENT NAME: WESTMOUNT HEALTH FACILITY

DATE: January 22, 2010

- (a) Purpose of Contract Change: Amend Contract to include additional expenditures not to exceed \$3,000.00 for matters relating billing.
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: Resolution Number 660 of 2009.
- (c) Name of Contractor: Ruffo Tabora Mainello & McKay PC
- (d) Address of Contractor: 300 Grat Oaks Boulevard, Suite 311, Albany, NY 12203
- (e) Contractor's Contact Person and Telephone Number: David Ruffo 518 218-2088
- (f) Commencement Date of Extension: Upon execution of agreement
- (g) Termination Date of Extension: Upon completion of agreement
- (h) Payment Provisions:
 - i) lump sum amount
 - ii) hourly rate amount
 - iii) total amount not to exceed 3,000.00
 - 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: EF.83500.6822 470 Westmount, Administrative Services, Contracted Services, \$3,000.00.

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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: January 22, 2010

- (a) Purpose of Amendment: Request to Amend 2010 Administrative Contracted Services Appropriations by Amending the Unrestricted Fund Balance.

- (b) Appropriation Code (with title), Object Code (with title) and Amount: EF.83500.6822 470 \$3,000.00 Westmount, Administrative Services, Contracted Services.

- (c) Revenue Code (with title), and Amount: EF.229000 909.00 Westmount, Unrestricted Fund Balance \$3,000.00

REQUESTED PERSONNEL CHANGES FOR 2010*

*****PLEASE NOTE: ITEM NO. 3 MUST BE COMPLETED*****

DEPARTMENT: WESTMOUNT HEALTH FACILITY

BUDGET CODE: 41.00

SALARY BUDGET CODE: EF.60100.100 110

1) REQUEST FOR NEW POSITION OR DELETE POSITION: NEW DELETE

TITLE:

SALARY: \$

HIRE DATE:

GRADE:

REASON FOR REQUEST:

IS ANY POSITION TO BE DELETED? YES NO

IF YES: TITLE:

SALARY: \$

GRADE:

IS POSITION REQUESTED TO BE OUTSIDE OF BARGAINING UNIT: YES NO

IF YES, REASON:

2) REQUEST FOR RECLASSIFICATION OF POSITION:

EMPLOYEE NUMBER:

CURRENT TITLE: Assistant Director of Nursing

HIRE DATE:

2009 BASE SALARY: \$ 58700.86

GRADE:

2010 BASE SALARY: \$ 48700.86

GRADE:

PROPOSED TITLE: MDS Coordinator

2010 BASE SALARY: \$ 48700.86

GRADE:

REASON FOR REQUEST: Restructure of Responsibilities

3) DATE OF SUPERVISORY COMMITTEE APPROVAL: _____

***Following any Approval, a New Position Duty Statement OR Job Classification information Must be completed by the department head and submitted to the Personnel Officer for position classification.**

NOTE: If request for reclassification of position is approved, the current position (one to be reclassified) will be abolished after the candidate successfully completes examination (if required), or 1/1/10, if examination is not required.

WESTMOUNT CURRENT STAFFING LEVELS JANUARY 2010

		POSITIONS	CURRENT STAFF	EMPLOYEE STATUS
7AM - 3PM	RN F/T	4	4	
	RN P/T	1	0	1 VACANCY
	LPN F/T	3	3	1 FLOA
	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	1	
	RN PER-DIEM	8	7	
	LPN F/T	3	3	
	LPN PER-DIEM	7	6	
	CNA F/T	12	12	
	CNA PER-DIEM	12	8	4 VERY LIMITED AVAILABILITY
	SUBTOTALS	44	38	

11PM - 7AM	RN F/T	1	1	
	LPN F/T	3	3	
	CNA F/T	8	8	
	SUBTOTALS	12	12	

GRAND TOTALS 84 77

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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

January 20, 2010

#4100	Nursing Administration	14.95	Hours - Overtime
#4101	RN Supervisors	301.75	Hours - Overtime
#4102	RN	158.50	Hours - Overtime
#4103	LPN	424.35	Hours - Overtime
#4104	CNA	1,046.80	Hours - Overtime
#4105	Activities	00.00	Hours - Overtime
#4109	Dietary	338.35	Hours - Overtime
#4110	Maintenance	10.00	Hours - Overtime
#4111	Housekeeping	72.00	Hours - Overtime
#4112	Laundry	32.00	Hours - Overtime
#4114	Fiscal Services	31.35	Hours - Overtime

HOLIDAY (4)

#4101	RN Supervisors	192.00	Hours - Overtime
#4102	RN	96.00	Hours - Overtime
#4103	LPN	216.00	Hours - Overtime
#4104	CNA	864.00	Hours - Overtime
#4109	Dietary	258.00	Hours - Overtime
#4111	Housekeeping	72.00	Hours - Overtime
#4112	Laundry	32.00	Hours - Overtime

Report Dates - 11/09/09 - 01/17/10

#4101	109.74
#4102	62.50
#4103	208.35
#4104	182.80
#4109	80.35
#4111 & #4112	- ALL HOLIDAY

11

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 hereby authorizes Barbara Taggart
(Supervisory Committee) (Employee Name)

to attend American College of Health Care Administrators 41st Annual Convention
(Name of meeting or organization)

at Villa Roma Resort & Conference Center
(Address)

on 3/14-3/17/10 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 \$ 110.00 GSA* Rate \$ 113.00

Meal costs - GSA*per diem rate \$ _____

*www.gsa.gov

Date: 1/22/10


Department Head Signature

Date: 1/22/10


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

No 37511

42 Gurney Lane
Queensbury, NY 12804

American College of Health
Care Admin.

Vendor
Name &
Address

Check # _____

Date Paid _____

DATE	DATE REQUIRED	TERMS	F.O.B.	SHIP VIA	DEPT. OF REQ. NO.	FOR OUR USE	FOR REGRS
1/21/10					Admin	<input type="checkbox"/>	<input type="checkbox"/>
QUANTITY	DESCRIPTION				PRICE	AMOUNT	
	41 st Annual Convention - Solving Today's Health Care Challenges and Preparing for the Future 3/14-3/17/10 Registration (member)					99.00	
	Room (3 nights @ 110.00 per night)					330.00	
						429.00	

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	83500	8800		0260	444	

REC'D BY _____

DATE _____

APPROVED BY _____

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

ADMINISTRATOR REGISTRATION

NEW YORK CHAPTER OF THE AMERICAN COLLEGE OF HEALTH CARE ADMINISTRATORS 41st ANNUAL CONVENTION

Villa Roma Resort & Conference Center, Callicoon, New York, March 14 - March 17, 2010

IMPORTANT:

1. This program has been submitted to the NJ Board of Examiners of Nursing Home Administrators for 16 continuing-education hours.
2. ACHCA Cancellation Policy: Full refund on cancellations postmarked no later than February 1st. There will be a \$50 administrative fee charged after that date. No refund after February, 15, 2010.
3. Program reservations should be made directly with NYC ACHCA 875 Jerusalem Ave., Uniondale, NY 11553 (see form).
4. \$25 of non-member registration fee may be applied to College membership if the application is mailed within 60 days of this Convention.
5. Complete Convention registration form; make check payable to New York Chapter/ACHCA/ mail to New York Chapter, ACHCA, c/o Anthony Restaino, 875 Jerusalem Ave., Uniondale, NY 11553

REGISTRATION FEE INCLUDES:

- Socials
- Educational programs and all literature and educational materials
- Entrance to exhibit hall
- Entertainment
- Coffee breaks
- ACHCA welcoming gifts
- Convention Journal
- Completing Your Professional Development Plan for Certification

For further information please contact:
LARRY I. SLATKY (516) 572-1400

CONVENTION REGISTRATION FORM

41st Annual Convention of the New York Chapter of the American College of Health Care Administrators

If you wish to enroll additional participants, please attach separate paper with the same type of information requested on this form. ALL REGISTRATIONS MUST BE PREPAID.

PLEASE PRINT.

Name (A) Barbara Taggart
 Title Administrator
 Name (B) _____
 Title _____
 Spouse/Guest _____
 Facility Westmont Health Facility
 Address 42 Burney Lane
 City Queensbury, NY
 State Zip New York
 Phone (518) 761-6548
 License No./State (A) _____
 License No./State (B) _____

ADVANCE CONVENTION REGISTRATION

Member Fee (A)** (\$99.00 ea.)	\$ 99.00
Member Fee (B)** (\$99.00 ea.)	\$ _____
Non-Member Fee (\$250.00 ea.)	\$ _____
Spouse/Guest/Student***(\$70.00 ea.)	\$ _____
Total Remittance	\$ _____

** If your administrator is a member of ACHCA, NYAUSA or NYSHFA
 *** Student of long term care (A.I.T.)
 *** Spouse with no license

ON SITE REGISTRATION FEE:

Member \$195.00	Non-Member \$300.00
-----------------	---------------------

Is this your first Convention? Yes No Are you a new member (2008-2009 Year)? Yes No

Registration confirmed _____

Make checks payable to:
 New York Chapter of the American
 College of Health Care Administrators

Return to: Anthony Restaino
 ACHCA/NYC
 875 Jerusalem Ave., Uniondale, NY 11553

VILLA ROMA RESORT & CONFERENCE CENTER REGISTRATION FOR THE NEW YORK CHAPTER OF THE AMERICAN COLLEGE OF HEALTH CARE ADMINISTRATOR CONVENTION

Villa Roma Resort & Conference Center, Callicoon, NY
 Telephone (800) 727-8455
 Sunday, March 14 through Wednesday, March 17, 2010

Room Category	Group Rates (per person double occupancy)	Single Per-Day Supplement
2 Bedroom Suite	\$150.00	\$50.00
1 Bedroom Suite	\$130.00	\$20.00
<u>Deluxe</u>	\$110.00	\$20.00

The above DAILY rates are quoted Full American Meal Plan (three meals daily, beginning with dinner of the day of arrival and concluding with lunch on the day of departure), net, non-commissionable, plus applicable tax. One night stay \$10.00 additional. Triple occupancy is charged at 80% of the group rate. Check-in time: Rooms will be available by 4:00 P.M. - early arrivals will be welcome to use the hotel's facilities prior to checking in.

Gratuities: A gratuity of \$12.00 per person, per day will be added to your bill to cover dining room waiters, busboys, and chambermaids.

Payment/Taxes: You may pay your bill by check, cash, or credit card. Rates are subject to 8% state and local sales taxes plus 2.5% occupancy tax. If you are tax-exempt, please give the front desk a signed NYS Tax Exemption certificate when you check in.

HOTEL REGISTRATION FORM

Please cut along dotted line and mail this application to:

Villa Roma Resort & Conference Center - ACHCA/NYC

Name (please print) Barbara Taggart
 Company Name (mandatory) Westmont Health Facility
 Address 42 Burney Lane City _____
 State NY Zip 12804 Tel: 518-761-6548
 Date of Arrival 3/14/10 Date of Departure 3/17/10
 I am accompanied by my spouse/guest (Name) _____
 Children _____ Sharing Room (Name) _____

Accommodations desired (check one)
 2 Br 1 Br Deluxe REGULAR DINING
 GLATT KOSHER (MAUZONE'S)

Deposit: Please return reservation form with a \$100 deposit per person. Rooms will be assigned on a first-come, first-served basis. Requests received after February 1 are subject to availability.

Please make checks payable to the Villa Roma Resort & Conference Center and mail to: Villa Roma Resort & Conference Center, 356 Villa Roma Road, Callicoon, NY 12723. The hotel will acknowledge reservations. Deposits will be refunded if the hotel is notified one week prior to arrival. NO TELEPHONE RESERVATIONS PLEASE.