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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265858 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/22/2025 |
| NAME OF PROVIDER OR SUPPLIER E W Thompson Health & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 975 Mitchell Road Sedalia, MO 65301 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50432</p> <p>Based on observation, interview, and record review, facility staff failed to ensure a medication error rate of less than 5% out of 25 opportunities observed. Four errors occurred, resulting in a 16% error rate, which affected four residents (Residents #22, #36, #47 and #64) of six sampled residents. The facility census was 60.</p> <p>1. Review of the facility policy titled, Insulin Administration Policy, not dated, showed nursing staff will have access to specific instructions (from manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use.</p> <p>Review of the Insulin Aspart Injection manufacturer insert showed:</p> <p>Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:</p> <ul style="list-style-type: none"> -Turn the dose selector to select two units; -Hold the Insulin Aspart FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge; -Keep the needle pointing upwards, press the push button all the way in; -The dose selector returns to zero; -A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. <p>Review of the Novolog FlexPen manufacturer instructions showed:</p> <ul style="list-style-type: none"> -Give the air shot before each injection; -Turn the dose selector to select two units; -Hold the NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge; <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-Keep the needle pointing upwards, press the push bottom all the way. The dose selector returns to zero;</p> <p>-A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times;</p> <p>-If you do not see a drop of insulin after six times, do not use the NovoLog FlexPen and contact manufacturer.</p> <p>2. Review of Resident #22's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/11/24, showed staff documented the resident had a diagnosis of diabetes and received insulin injections seven out of the seven days in the look back period.</p> <p>Review of the Physician Order Sheet (POS), dated 10/24/24, showed an order for Insulin Aspart (Niacinamide) three times per day at 7:00 A.M., 11:00 A.M., and 5:00 P.M.</p> <p>Observation on 1/21/25 at 11:30 A.M., showed Certified Medication Technician (CMT) B dialed the resident's Humalog Kwik Pen to 18 units and administered the insulin to the resident. The CMT did not prime the insulin pen prior to administration.</p> <p>3. Review of Resident #36's Quarterly MDS, dated [DATE], showed staff documented the resident had a diagnosis of diabetes and received insulin injections seven out of seven days in the look back period.</p> <p>Review of the POS, dated 03/12/24, showed an order for NovoLog FlexPen Insulin Aspart 100 units/milliliter (ml). Three units three times per day at 7:30 A.M., 11:30 A.M., and 5:00 P.M.</p> <p>Observation on 1/21/25 11:40 A.M., showed CMT B dialed Resident #36's Novolog Pen to three units and administered the insulin to the resident. The CMT did not prime the insulin pen prior to administration.</p> <p>4. Review of Resident #47's Quarterly MDS, dated [DATE], showed staff documented the resident had a diagnosis of diabetes and received insulin injections seven out of seven days in the look back period.</p> <p>Review of the resident's POS, dated 11/22/24, showed an order for Novolog FlexPen Insulin Aspart 100 unit/ml four times per day at 7:00 A.M., 11:30 A.M., 5:00 P.M., and 8:00 P.M.</p> <p>Observation on 1/21/25 4:39 P.M., showed CMT C dialed Resident #47's Novolog Pen to four units and administered the insulin to the resident. The CMT did not prime the insulin pen prior to administration.</p> <p>During an interview on 01/22/25 at 1:05 P.M., CMT A said he/she is fairly new at administering insulin, and did not know insulin pens should be primed. The CMT said he/she does not recall that being included in his/her training.</p> <p>(continued on next page)</p> | | |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>5. Review of the facility policy titled Administering Medications, dated April 2019, showed medications are administered in accordance with prescriber orders, including any required timeframe. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.</p> <p>6. Review of Resident # 64's Admission MDS, dated [DATE], showed staff documented the resident had a diagnosis of dementia and anxiety disorder.</p> <p>Review of the resident's POS, dated 01/19/25, showed an order for Doxycycline Hydate (antibiotic) 100 milligrams (mg) capsule. One capsule by mouth twice per day at 8:00 A.M., and 8:00 P.M., for cellulitis (a bacterial infection of the skin and underlying tissues).</p> <p>Review of the Medication Administration Record (MAR), dated 01/20/25, showed CMT A did not document he/she administered the Doxycycline Hydate 100 mg at 8:00 A.M. as prescribed.</p> <p>Observation on 1/20/25 at 8:35 A.M. showed CMT A did not administer Doxycycline 100 mg during the morning medication pass or indicate a reason in the MAR.</p> <p>During an interview on 1/22/25 at 1:10 P.M., CMT A said he/she could not find the resident's doxycycline in the medication cart, so he/she made a note to remind him/her to talk to the supervisor. CMT A notified Licensed Practical Nursed (LPN) G the morning of 1/22/25 that the medication could not be found in the medication cart. The CMT said he/she did not notify the supervisor timely because he/she got busy.</p> <p>7. During an interview on 1/22/25 at 1:35 P.M., the Director of Nursing (DON) said staff should prime insulin pens with two units of insulin. The DON said staff prime the needle to remove air. The DON said if staff does not prime the insulin pen, then the resident would not get the correct amount of insulin. The DON said he/she did not know staff did not know they were supposed to prime insulin pens. The DON said staff are expected to follow the Administering Medication policy when a medication cannot be located in the medication cart. He/She said if a medication can not be found staff should check the emergency kit and notify the charge nurse. If staff are unable to administer a medication they should circle and initial it on the MAR.</p> <p>During an interview on 1/22/25 at 3:02 P.M. the Administrator said he/she expects staff to follow physician orders and policy/device manufacturer instructions when administering medications. The Administrator expects CMTs to know how to ensure a full dose of insulin is administered, which is priming the pen prior to administration. The Administrator said if staff can not find a medication in the cart a hold should be initiated in the MAR by selecting the Hold button. He/She said staff should document the reason for the hold in the MAR. The Administrator said he/she knows the policy states staff are to circle and initial next to the medication on the MAR, but this not current practice.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>33477</p> <p>Based on observation, interview and record review, the facility staff failed to perform hand hygiene as often as necessary using approved techniques to prevent cross-contamination. The facility census was 60.</p> <p>1. Review of the facility's Food and Nutrition Services Hand Washing policy, dated 01/01/07, showed the policy directed staff to wash their hands:</p> <ul style="list-style-type: none"> -During food preparation; -When switching between raw food and work with ready-to-eat food; -Before donning gloves for working with food; -After handling soiled utensils or equipment; -After engaging in other activities that contaminate the hands. <p>Review showed the procedure for handwashing listed as:</p> <ul style="list-style-type: none"> -Rinse hands under clean, running, warm water; -Apply a cleaning compound; -Rub together vigorously for approximately 10 to 15 seconds; -Rinse thoroughly under clean, running, warm water; -Shut off the water faucet without contaminating the clean hands (id est, by using a paper towel). <p>Review of the facility's Handwashing/Hand Hygiene policy, dated August 2015, showed The facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Review showed the policy directed staff to perform hand hygiene:</p> <ul style="list-style-type: none"> -When hands are visibly soiled; -Before and after coming on duty; -Before donning gloves; -After removing gloves; -Before and after eating or handling food. <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Review showed the procedure for handwashing listed as:</p> <ul style="list-style-type: none"> -Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum or 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature; -Rinse hands thoroughly under running water; -Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. <p>Observation on 01/20/25 at 4:15 P.M., showed [NAME] H scrubbed his/her hands with soap under running water for four seconds and turned off the faucet with his/her bare wet hands at the handwashing sink. Observation showed the cook donned gloves, cleaned the food preparation counter, removed his/her soiled gloves, lifted the lid of the trash can with his/her bare hand to dispose of the gloves and then washed his/her hands at the handwashing sink. Observation showed the cook scrubbed his/her hands with soap under running water and turned off the faucet with his/her wet bare hands. Observation showed the cook then donned gloves and cut raw cucumbers to prepare the tomato and cucumber salad for service to the residents.</p> <p>Observation on 01/20/25 at 4:20 P.M., showed [NAME] H removed his/her soiled gloves, lifted the trash can lid with his/her bare hand to dispose of the gloves and then washed his/her hands at the handwashing sink. Observation showed the cook scrubbed his/her hands with soap under running water and turned off the faucet with his/her wet bare hands. Observation showed the cook then donned gloves and continued to cut raw cucumbers to prepare the tomato and cucumber salad for service to the residents.</p> <p>Observation on 01/20/25 at 4:29 P.M., showed [NAME] H removed his/her soiled gloves, lifted the trash can lid with his/her bare hand to dispose of the gloves and then washed his/her hands at the handwashing sink. Observation showed the cook scrubbed his/her hands with soap under running water and turned off the faucet with his/her wet bare hands. Observation showed the cook then donned gloves and prepared scalloped potatoes for service to residents at the evening meal.</p> <p>During an interview on 01/20/25 at 4:30 P.M., [NAME] H said he/she had worked at the facility since June 2024 and staff trained him/her on hand hygiene procedures upon hire. The cook said staff should wash their hands before food preparation, after they remove gloves and after they touch anything dirty. The cook said a trash can lid would be considered a dirty piece of equipment. The cook said staff should scrub their hands with soap, out of the water, for 20 seconds and turn the faucet off with a paper towel when they wash their hands. The cook said he/she did not know why he/she did not scrub his/her hands properly or why he/she turned off the faucet with his/her bare hands other than he/she was just in a hurry.</p> <p>Observation on 01/21/25 at 9:28 A.M., showed Dietary Aide (DA) I scrubbed his/her hands with soap for five seconds when he/she washed his/her hands at the handwashing sink. Observation showed the DA then put away sanitized from the mechanical dishwashing station.</p> <p>Observation 01/21/25 at 9:31 A.M., showed DA J washed soiled dishes in the mechanical dishwashing station. Observation showed, without performing hand hygiene, the DA then put away sanitized dishes from the clean side of the station.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Observation on 01/21/25 at 9:36 A.M., showed DA J scrubbed his/her hands with soap for three seconds and turned the faucet off with his/her wet bare hands at the handwashing sink. Observation showed the DA dried his/her hands with a paper towel, used his/her bare hand to lift the lid of the trash can to dispose of the paper towel, and then put sanitized dishes away from the clean side of the mechanical dishwashing station.</p> <p>Observation on 01/21/25 at 9:56 A.M., showed DA J cleaned the counter of the dirty side of the mechanical dishwashing station and then washed his/her hands at the handwashing sink. Observation showed the DA scrubbed his/her hands with soap for seven seconds and turned the faucet off with his/her wet bare hands. Observation showed the DA then put sanitized dishes away from the clean side of the mechanical dishwashing station.</p> <p>During an interview on 01/21/25 at 9:57 A.M., DA J said he/she had worked at the facility for three years and he/she had been trained on hand hygiene during his/her employment. The DA said staff should scrub their hands with soap for 20 seconds and use a paper towel to turn the water off when they wash their hands. The DA said he/she did not have a reason for why he/she did not scrub his/her hands with soap longer or for not using a paper towel to turn off the water.</p> <p>Observation on 01/21/25 at 11:00 A.M., showed DA I scrubbed his/her hands with soap for four seconds when he/she washed his/her hands at the handwashing sink. Observation showed the DA then put sanitized dishes on a service cart.</p> <p>During an interview on 01/21/25 at 11:16 A.M., the Dietary Manager (DM) said staff should wash their hands after they remove gloves or touch anything dirty and a trash can lid would be considered dirty. The DM said staff should scrub their hands with soap, out of the water, for 20 seconds and use a clean, dry paper towel to turn off the faucet when they wash their hands. The DM said all staff are trained on proper hand hygiene procedures upon hire and as needed.</p> <p>During an interview on 01/21/25 at 1:00 P.M., the administrator said staff should wash their hands any time they are soiled or when they go from a dirty task to a clean task. The administrator said staff should scrub their hands with soap, out of the water, long enough to sing the ABC song twice which should take them about 30 seconds and use a fresh paper towel to turn off the faucet when they wash their hands. The administrator said all staff are trained on proper hand hygiene procedures upon hire.</p> <p>42484</p> | | |

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| <p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>42484</p> <p>Based on interview and record review, facility staff failed to electronically submit to the Centers for Medicare and Medicaid Services (CMS), complete and accurate direct care staffing information to the Payroll Based Journal (PBJ) data on the schedule specified by CMS from January 1, 2024, through July 31, 2024. The facility census was 60.</p> <p>1. Review of the facility's Reporting Direct Care Staffing Information (Payroll-Based Journal) policy, revised August 2022, showed:</p> <ul style="list-style-type: none"> -Direct care staffing information is reported electronically to CMS through the PBJ; -Complete and accurate direct care staffing information is reported electronically to CMS through the PBJ system in a uniform format specified by CMS; -For auditing purposes, reported staffing information is based on payroll records, invoices, tied back to a contract, or other verifiable information; -Data is submitted only by designated personnel with training on the PBJ user interface; -Direct care staffing information is submitted on the schedule specified by CMS, but no less frequently than quarterly; -Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. Dates are as follows: <p>Fiscal Quarter 1 - Date Range October 1-December 31 - submission deadline February 14;</p> <p>Fiscal Quarter 2 - Date Range January 1-March 31 - submission deadline May 15;</p> <p>Fiscal Quarter 3 - Date Range April 1-June 30 - submission deadline February 14;</p> <p>Fiscal Quarter 4 - Date Range July 1-September 30 - submission deadline November 14.</p> <p>Review of the CMS Electronic Staffing Data Submission Payroll-Based Journal Policy Manual for submission guidelines showed submissions must be received by the end of the 45 th calendar day (11:59 PM Eastern Standard Time) after the last day in each fiscal quarter to be considered timely.</p> <p>Below are the deadlines for each reporting period:</p> <p>Fiscal Quarter 1 - Date Range October 1-December 31 - submission deadline February 14;</p> <p>Fiscal Quarter 2 - Date Range January 1-March 31 - submission deadline May 15;</p> <p>Fiscal Quarter 3 - Date Range April 1-June 30 - submission deadline February 14;</p> <p>(continued on next page)</p> | | |

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| <p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Fiscal Quarter 4 - Date Range July 1-September 30 - submission deadline November 14.</p> <p>3. Review of the facility's CMS PBJ Staffing Data Report, dated July 1-September 30, showed the facility had a One Star Staffing Rating.</p> <p>During an interview on 01/22/25 at 3:02 P.M., the administrator said the facility is ultimately responsible to submit information for the PBJ. The facility was in the process of switching payroll administration to a new company in February. The facility expected the new payroll company to enter the PBJ information as required, and this did not happen. In April, facility staff realized the information had not been submitted for Fiscal Quarter one and it was submitted late. The process should have been corrected however the next deadline for submission was also missed.</p> <p>During an interview on 01/29/25 at 11:02 A.M., the HR manager said the facility switched to a new company to handle payroll, and the new company was to format information for the PBJ. The company did not come through with this task, and he/she had to convert information and enter the PBJ manually for Quarter 1. The company still did not fix the issue and the next quarter again was not submitted timely, and the HR manager had to enter the information manually again.</p> |