STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265352	A. BUILDING _____ B. WING _____	10/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST COUNTY CARE CENTER	**312 SOLLEY DRIVE BALLWIN, MO 63021**

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)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents by failing to provide safe transfers for two of three sampled residents (Residents #1 and #2). The census was 42. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/30/20, showed the following: -admission date of [DATE], readmission date of [DATE]; -Brief Interview for Mental Status (BIMS, a screening tool used to determine cognitive impairment) score of 15 of a possible 15, (cognitively intact); -Required physical assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene; -Impairments on both sides of upper body; -Impairments on both sides of lower body; -Used a wheelchair for ambulation; -[DIAGNOSES REDACTED]. Review of the resident's care plan, last revised on 7/8/20, showed the following: -Focus: The resident has altered safety awareness and non-compliance with safety. The resident has a history of falls and not asking for assistance prior to transfer; -Goal: No major injury related to falls through next review; -Intervention: The resident will call for assistance to stand and understands staff is required to use a gait belt when helping the resident to stand or transfer to prevent falls; Observation on 10/15/20 at 10:00 A.M., showed the resident lying in his/her bed. Certified Nurse Assistant (CNA) A helped the resident to a sitting position on the side of the bed by placing his/her hands under the resident's arms. With his/her hands under the resident's arms, CNA A then picked the resident up off of the bed and placed the resident in his/her wheelchair. The resident's feet did not touch the ground during the transfer. The CNA did not use a gait belt to help the resident sit up from a laying position. The CNA did not use a gait belt to help transfer the resident from his/her bed to the wheelchair. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed the following: -admission date of [DATE], readmission date of [DATE]; -BIMS score of 15 of 15; -Required physical assistance of one person with transfers, dressing, toilet use and personal hygiene; -Used a wheelchair for ambulation; -[DIAGNOSES REDACTED]. Review of the resident's care plan, last revised on 6/17/20, showed the following: -Focus: The resident was at risk for falls related to [MEDICAL CONDITION] arthritis, daily anti-depressant use, and impaired vision; -Goals: Fall risk will decrease through review date; -Intervention included: Encourage the resident to use a call light and request assistance when feeling tired or weak; -There was no documentation included in care plan on how to assist the resident with transfers. Review of the resident's physician order [REDACTED]. Observation on 10/15/20 at 10:13 A.M., showed CNA A entered the resident's room. The resident lay on his/her bed. CNA A helped the resident to a sitting position by placing his/her hand under the resident's arm. The CNA did not use a gait belt. The CNA helped the resident remove his/her gown and put on a clean shirt. CNA A assisted the resident to a standing position by grabbing the resident's upper arm with his/her hand. CNA A then helped the resident remain steady on his/her feet by holding the resident underneath his/her arm and pulled the resident's shorts up to his/her waist, over visibly urine soaked briefs. The CNA did not use a gait belt when assisting the resident to transfer from a seated to a standing position. 3. During an interview on 10/15/20 at 10:23 A.M., CNA A said the following: -Residents' transfer status was found in their medical record and was told to CNAs during morning report; -He/she forgot to use a gait belt when transferring residents; -Gait belts are used for safety reasons, to help prevent injury to the residents during transfers. 4. During an interview on 10/15/20 at 1:12 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said the following: -Staff are expected to use gait belts when transferring residents to prevent accidents; -It was not safe to pick up a resident without the use of a mechanical lift due to the risks of dropping the resident, tearing the resident's skin, dislocating a resident's shoulder, or causing a broken or fractured bone due to unknown force.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility staff failed to provide infection control measures by not washing or sanitizing their hands between glove changes, not performing appropriate perineal care according to professional standards of care and touching residents' personal belongings with contaminated gloves for two of three sampled residents (Residents #1 and #2). The facility also failed to provide infection control measures by not posting the appropriate signs showing what personal protective equipment (PPE) should be worn when entering a COVID-19 positive unit, staff members failed to wear appropriate PPE when entering the COVID-19 positive unit and staff failed to change their masks after leaving the COVID-19 positive unit to provide care to other residents. The census was 42. Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic Infection Control Guidance, updated 7/15/20, recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 (COVID-19) infection, showed: -Place a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection in a single-person room with the door closed. The patient should have a dedicated bathroom; -As a measure to limit health care professional (HCP) exposure and conserve personal protective equipment (PPE), facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection. Dedicated means that HCP are assigned to care only for these patients during their shift; -It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens might be cohorted (the practice of grouping together patients who are infected with the same organism to confine their care to one area and prevent contact with other patients) on the same unit. However, only patients with the same respiratory pathogen may be housed in the same room. For example, a patient with COVID-19 should ideally not be housed in the same room as a patient with an undiagnosed respiratory infection or a respiratory infection caused by a different pathogen; -HCP who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions (minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered) and use a National Institute for Occupational Safety and Health (NIOSH)-approved N95 (particulate filtering facepiece respirator that filters at least 95 percent of airborne particles but is not resistant to oil) or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. -HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process; -Employers should select appropriate PPE and provide it to HCP in accordance with OSHA PPE standards. HCP must receive training on and demonstrate an understanding of when to use PPE, what PPE is necessary, how to properly don (put on), use, and doff (take off) PPE in a manner to prevent self-contamination, how

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) to properly dispose of or disinfect and maintain PPE, the limitations of PPE; -Cloth face coverings are NOT PPE and should not be worn for the care of patients with suspected or confirmed COVID-19 or other situations where use of a respirator or facemask is recommended. Review of the CDC Coronavirus Disease 2019 (COVID-19) Responding to Coronavirus (COVID-19) in Nursing Homes, Resident Cohorting, updated 4/30/20, showed: -Determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit; -Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care unit, should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g., the majority of residents in the facility are already infected); -Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms; -Ensure that HCP have been trained on infection prevention measures, including the use of and steps to properly put on and remove recommended PPE; -Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing -Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents; -If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit; -Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other resident unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit); -Exposed resident may be permitted to room share with other exposed residents if space is not available for them to remain in a single room; -HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents. The CDC Coronavirus Disease 2019 (COVID-19), Considerations for Wearing Masks, updated 8/7/20, showed; -The purpose of masks is to keep respiratory droplets from reaching others to aid with source control (use of cloth face coverings or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing). However, masks with one-way valves or vents allow air to be exhaled through a hole in the material, which can result in expelled respiratory droplets that can reach others. This type of mask does not prevent the person wearing the mask from transmitting COVID-19 to others. Therefore, CDC does not recommend using masks for source control if they have an exhalation valve or vent; -A face shield is used primarily for eye protection for the person wearing it. At this time, it is not known what level of protection a face shield provides to people nearly from the spray of respiratory droplets from the wearer. There is currently not enough evidence to support the effectiveness of face shields for source control. Therefore, CDC does not currently recommend use of face shields as a substitute for masks. Review of the CDC Coronavirus Disease 2019 (COVID-19) Clinical Questions about COVID-19: Questions and Answers Infection Control section, updated 10/5/20, showed PPE used by infected HCP - HCP wearing a facemask (or respirator) and face shield that extends down below the chin might have had better source control than wearing only a facemask. Note that respirators with exhalation valves might not provide source control. Review of the CDC Strategies for Optimizing the Supply of N95 Respirators Conventional Capacity Strategies (should be incorporated into everyday practices), updated 6/28/20, showed cohorting is the practice of grouping together patients who are infected with the same organism to confine their care to one area and prevent contact with other patients. Cohorts are created based on clinical diagnosis, microbiologic confirmation when available, epidemiology, and mode of transmission of the infectious agent. When single patient rooms are not available, patients with confirmed COVID-19 may be placed in the same room. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 7/30/20, showed the following: -admission date of [DATE], readmission date of [DATE]; -Brief Interview for Mental Status (BIMS, a screening tool used to determine cognitive impairment) score of 15 of a possible 15, (cognitively intact); -Required physical assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene; -Impairments on both sides of upper body; -Impairments on both sides of lower body; -Used a wheelchair for ambulation; -[DIAGNOSES REDACTED]. Review of the resident's care plan, last revised on 7/8/20, showed the following: -Focus: The resident requires assistance with activities of daily living (ADLs); -Goal: The resident will have his/her ADL needs met with the assistance needed through the next review; -Interventions: Assist with perineal care (peri-care, washing the front and back of the hips, genitals, anal area and buttocks). Observation on 10/15/20 at 9:55 A.M., showed Certified Nurse Assistant (CNA) A used a towel to mop up a wet, unidentified substance on the hall floor. He /she then threw the soiled towel into a linen cart and walked down the hall to the resident's room. CNA A entered the room, did not sanitize his/her hands or don gloves, then removed clean clothes from the resident's closet and placed them at the foot of the resident's bed. The resident was lying on the bed, on his/her right side. CNA A washed his/her hands, donned gloved and proceeded to perform perineal care to the resident. CNA A lifted the blanket off of the resident, took one cleansing wet wipe in a gloved hand and wiped the resident's left inner thigh. Using the same wipe, CNA A wiped the resident's right inner thigh. CNA A threw away the soiled wipe and assisted the resident over to his/her left side. CNA A did not clean the resident's entire perineal area. CNA A did not sanitize his/her hands and don new gloves. CNA A took a new wet wipe from the package and wiped the resident's entire buttocks using a circular motion. CNA A did not cleanse the resident's anus. CNA A threw away the soiled wipe, and dressed the resident with a clean brief and pants. The CNA did not sanitize his/her hands and don new gloves before moving to the next task. CNA A placed his/her soiled, gloved hands under the resident's arms, picked the resident up off the bed and transferred him/her to a wheelchair. CNA A, still wearing soiled gloves, searched through the resident's clean clothes located in his/her dresser, then assisted the resident with putting on his/her shirt. CNA A removed the linen from the resident's bed, folded them up in his/her arms, picked up a dirty cup from the resident's bedside table and left the resident's room. The CNA did not bag the dirty laundry items before carrying them out of the room and did not sanitize and remove his/her gloves before walking in the hall. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed the following: -admission date of [DATE], readmission date of [DATE]; -BIMS score of 15 out of a possible 15; -Required physical assistance of one person with transfers, dressing, toilet use and personal hygiene; -Used a wheelchair for ambulation; -[DIAGNOSES REDACTED]. Review of the resident's care plan, last revised on 6/17/20, showed the following: -Focus: The resident has a history of urinary tract infections (UTI, infection in any part of the urinary system, the kidneys, bladder, or urethra); -Goal: To have fewer UTIs through the next review date. -Interventions included: Observe the resident to insure he/she was performing proper peri-care. Observation on 10/15/20 at 10:10 A.M., showed CNA A entered the COVID-19 isolation hall. There was a red sign hanging on the outside of the closed doors, Stop. Go see nurse. There was not a collection of clean PPE (gowns, gloves, face masks, goggles) outside the isolation unit. There was not a sign on the door of the isolation unit instructing staff what PPE to don. The CNA did not don a gown, gloves, goggles or a facemask before entering the isolation unit. The CNA walked into a room which had a blinking call light on, turned off the call light, and then exited the room. CNA A left the isolation unit. There was not a sign on the inside of the door of the isolation unit with instructions on what PPE to doff before exiting the unit. The CNA did not sanitize his/her hands or change his/her mask after exiting the isolation unit. CNA A walked over to a nurse's cart, took a large handful of clean gloves out of their box, and placed them in his/her shirt pocket. Observation on 10/15/20 at 10:13 A.M., showed CNA A entered the resident's room. CNA A donned a pair of gloves from his/her pocket. The CNA did not sanitize his/her hands before donning gloves. CNA A gathered clean clothes from the resident's room and placed them on the resident's bed. The resident was lying on his/her bed. CNA A removed the blanket from the resident, pulled clean shorts up to the resident's knees, and placed shoes on the resident's feet. CNA A then helped the resident to a sitting position by placing his/her hand under the resident's arm. The CNA helped the resident remove his/her gown and put on a clean shirt. CNA A assisted the resident to a standing position by grabbing the resident's upper arm with his/her hand. CNA A then helped the resident remain steady on his/her feet by holding the resident underneath his/her arm, and pulled the resident's shorts up to his/her waist, over a pair of visibly urine soaked briefs. The resident used his/her walker to ambulate over to the bathroom and stood in front of the toilet. CNA A pulled the resident's shorts and soiled brief down. The CNA touched the inside, center of the brief which was visibly soiled with urine. The CNA removed his/her gloves. CNA A removed the resident's soiled brief with his/her bare hands, and threw it in the trash. CNA A washed his/her hands, donned gloves, and grabbed toilet paper to assist the resident with perineal care. CNA A wiped the resident's genital area with toilet paper, using a front to back motion. The CNA threw away the soiled toilet paper, grabbed a handful of clean toilet paper, and wiped the resident's genital area again. The CNA did not sanitize his/her hands and don new gloves before moving to the

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) next task. CNA A pulled a wet wipe from the package and wiped the resident's anus from front to back. CNA A took the same, soiled wipe, folded it in half, and wiped the resident's inner thighs and genital area, using a back to front motion. The CNA did not sanitize his/her hands and don new gloves when going from a dirty to clean task. The CNA did not use a clean wet wipe for each area of the resident's perineal area. With the same soiled gloves, CNA A pulled the resident's clean shorts up around the resident's waist. 3. During an interview on 10/15/20 at 10:23 A.M., CNA A said the following: -He/she had enough PPE to complete his/her work tasks; -He/she forgot to don a gown, gloves, goggles or mask before entering the COVID-19 isolation unit; -He/she entered a room on the isolation unit to turn off a call light; -He/she did not sanitize his/her hands or change his/her mask after exiting the COVID-19 isolation unit; -It was important to don and doff the appropriate PPE before entering and exiting the COVID-19 isolation unit because a staff member could spread [MEDICAL CONDITION] to other residents and staff members; -He/she was still wearing the same mask that he/she had on while in the isolation unit. He/she needed to change it because it was germy; -The facility expected staff to sanitize their hands and don new gloves when going from a dirty to clean task. 4. During an interview on 10/15/20 at 1:12 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) said the following: -Staff are expected to follow policy and procedures; -They have enough PPE for staff to perform their duties safely; -Staff are expected to sanitize their hands and don new gloves when going from a clean to dirty task; -Staff are expected to clean resident's entire perineal area, wherever urine could have touched, in order to prevent skin breakdown; -Wet wipes should only be used to swipe a dirty area one time, then thrown away, due to infection control; -Staff are expected to use clean technique when touching residents' personal items; -Staff are expected to don a gown, gloves, a facemask and/or goggles before entering the COVID-19 isolation unit; -Staff are expected to doff PPE and change their mask before exiting the COVID-19 isolation unit in order to prevent the spread of COVID-19 to the rest of the residents and staff in the facility. 5. Review of the facility's undated skills check for perineal care, in use during the abbreviated survey, showed the following: -Gather equipment, explain procedure and screen resident for privacy; -Assist resident on to back. If not able to tolerate lying on back, assist to side-lying position; -Fill basin with warm soap and water or use pre-moistened wipes. Arrange bags at bedside for disposal of soiled wipes/wash cloths, briefs, clothing and linen; -Ask resident to separate legs and flex knees. If unable to lie on back, perineal area can be cleaned with resident lying on side with knees flexed; -Clean resident front to back, use new area of wipe/wash cloth for each swipe, up to two swipes per wipe/washcloth; -With non-dominant hand, separate the labia (the inner and outer folds of the vulva, at either side of the vagina). Clean inner labia from front to back; -Clean along outside of labia and inner thighs. Pat perineal area dry. Cover resident with top linen for privacy; -Turn resident to side, clean perineal and rectal area, wiping from resident's front to back. Do not use a back and forth motion; -Clean buttocks on both sides. Pat dry. Cover resident with top linen for privacy; -Remove gloves, wash hands and apply clean gloves. Apply barrier cream from front to back. Apply clean brief or preferred under clothes. Change linen if necessary; -Cover resident with top linen for privacy. Remove gloves and wash hands; -Assist resident to comfortable position with call light in reach; -Dispose of wipes/wash clothes, linens, briefs in designated location. Do not leave soiled briefs/wipes in trash can; -Clean equipment and return to proper storage area; -Document procedure in designated location.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on interview and record review, the facility failed to provide cumulative updates to residents, their representatives, and families by 5:00 P.M., the next calendar day following the subsequent occurrence of either: each time a confirmed Coronavirus disease 2019 (COVID-19) infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. The census was 42. Review of the facility letters sent to residents, family members and responsible parties, showed the following: -On 6/25/20, the letter detailed the company's plan toward management of COVID-19 virus; -The facility did not list any positive COVID-19 cases in the 6/25/20 letter; -On 10/5/20, the letter detailed general guidelines for visitation during the COVID-19 pandemic; -The facility did not list any positive COVID-19 cases in the 10/5/20 letter; -The facility did not provide any proof of additional letters sent to the residents, family members and responsible parties. Review of the facility's documentation of positive COVID-19 cases, dated 10/15/20, showed the following: - On 8/31/20, one resident positive, one staff positive; -On 9/3/20, nine residents positive, one staff positive; -On 9/4/20, four residents positive, three staff positive; -On 9/6/20, one resident positive, one staff positive; -On 9/8/20, one staff positive; -On 9/9/20, three residents positive, one staff positive; -On 9/10/20, one staff positive; -On 9/11/20, four residents positive, one staff positive; -On 9/12/20, one resident positive; -On 9/13/20, two residents positive; -On 9/16/20, one resident positive; -On 9/19/20, two residents positive; -On 9/27/20, one resident positive, one staff positive; -On 10/6/20, two residents positive, one staff positive; -On 10/7/20, one resident positive, one staff positive; -On 10/12/20, three residents positive; -On 10/14/20, four residents positive, one staff positive. During an interview on 10/15/20 at 12:34 P.M., the administrator said the following: -He receives a list of COVID-19 positive cases as soon as they are resulted; -The administrator, Director of Nursing (DON), or the Assistant DON (ADON) contact positive staff members upon receiving their test results; -When a resident tests positive for COVID-19, he immediately informs the resident, the resident's responsible party, and family; -Once he contacts the residents' responsible party and family, the administrator writes a note detailing the conversation(s), and gives the note to the DON. The DON adds the notification note to the resident's medical record; -He is responsible to send out updates of COVID-19 cases to the residents, the residents' responsible parties and families; -He has not updated all residents, their responsible parties and families when there are new cases of COVID-19 in the facility, nor has he sent letters which provided weekly updates of the facility's COVID-19 status. Review of the facility's COVID-19 Action Plan, dated 7/8/20, showed the following: -The following guidance for notification is applicable if there is a confirmed case of COVID-19 diagnosed in a community resident or employee or contracted employee or in the event there are three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours; -Verbal communication immediately to the following: diagnosed resident; resident representative; local health department; state regulating agency; -All residents will be notified verbally by 5:00 P.M. the next calendar day of the positive notification of confirmed COVID-19 or three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other; -Written notification will also be sent to resident representatives; -Updates will be provided to residents and resident representatives weekly if no new cases or suspected cases occurred that week or by 5:00 P.M. the next calendar day following the subsequent occurrence of either a confirmed infection of COVID-19 is identified and/or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours.