

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Lifecare Roseau Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 715 Delmore Drive Roseau, MN 56751	

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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943</p> <p>Based on observation, interview, and document review, the facility failed to ensure urinary catheter care was provided in a manner to prevent contamination and potential urinary tract infection (UTI) for 1 of 1 residents (R30) reviewed for catheter cares.</p> <p>Findings include:</p> <p>R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30 had severe cognitive impairment and required an indwelling urinary catheter. Diagnoses included an enlarged prostate and obstructive uropathy (a condition where a blockage hinders the flow of urine).</p> <p>R30's care plan dated 3/28/24, identified R30 had indwelling urinary catheter related to obstructive uropathy and an enlarged prostate. The following interventions were implemented:</p> <ul style="list-style-type: none"> - Position catheter bag and tubing below the level of the bladder and away from entrance room door. - Monitor and document intake and output as per facility policy. - Monitor/document for pain/discomfort due to catheter. CNA - Monitor/record/report to MD for signs and symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. <p>The care plan also identified R30 was on Enhanced Barrier Precautions related to indwelling foley catheter use. Staff were to wear personnel protective equipment (PPE) as identified in EBP policy (gloves and gown, face protection if performing activity with high risk of splash), during high-contact resident care activities: Transferring, Providing Hygiene, Changing briefs or assisting with toileting and Device care or use.</p> <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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R30's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 4/3/24, identified the goal for R30 was to continue to transfer and ambulate safely independently and avoid complications. Staff were to assist with activities of daily living (ADLs) as needed and observe for increased dependence with ADLs and notify R30's physician (MF) of decline, encourage to participate in functional maintenance program to maintain abilities, encourage to attend group exercise, observe condition of skin daily with cares and weekly on bath day and notify MD of areas of concern, observe for symptoms of pain and offer prn pain medication and nonpharmacological interventions for pain and observe for effectiveness and notify MD if ineffective, assist with urinary catheter management and observe for complications and notify MD of concerns, observe for new or worsening symptoms of depression and side effects of Zoloft and notify MD of concerns, observe for social isolation, invite and encourage to attend meals and activities in the dining room, allow to vent frustrations, offer one to one visits. R30 was at risk for increased ADL dependence, falls with injury, skin breakdown, infections, worsening symptoms of depression, adverse behaviors, social isolation, frustration, anxiety, unmanaged pain, and unmet needs.</p> <p>During an observation on 4/8/25 at 3:53 nursing assistant (NA)-C assisted R30 back to his room from a group activity. NA-C offered toileting to R30, but R30 declined, and NA-C stated he would assist R30 to lie down in bed.</p> <p>- At 3:55 p.m., NA-C began to position R30's wheelchair next to R30's bed, but then stated NA-C needed to check R30's catheter leg to bag. NA-C put on gloves and raised R30's left pants leg to expose R30's catheter leg bag. The bag was approximately half full of amber colored urine. NA-C stated wait right here. I'll gown up. NA-C exited the room and put on a disposable gown, put on a pair of gloves then applied another pair of gloves on top. No hand sanitizer was used.</p> <p>- At 4:02 p.m., NA-C obtained R30's plastic graduate from R30's bathroom and placed it directly on the floor in front of R30. NA-C open R30's catheter leg bag port, drained the urine, then cleaned the port with an alcohol wipe. NA-C poured the urine in the toilet and rinsed the graduate. NA-C then removed the top layer of gloves but did not perform handwashing or used hand sanitizer.</p> <p>- At 4:04 p.m., NA-C placed a gait belt around R30 and assisted R30 into bed.</p> <p>-At 4:07 p.m., NA-C removed the gown and gloves and used hand sanitizer. NA-C stated he did not need to wash his hands or used hand sanitizer when he removed the top layer of gloves because he was wearing double gloves. I always do that. NA-C stated he had done the double glove thing a long time and had just seen it around. NA-C stated the double gloving probably shouldn't be done and only one pair of gloves should be worn at a time with hand sanitizer between. Additionally, NA-C stated he normally placed a disposable washcloth under the graduate when draining urine but did not do that. NA-C stated staff were instructed to do both to help prevent the spread of infection.</p> <p>During an interview on 4/9/25 at 10:02 a.m., registered nurse (RN)-B stated she was the facility infection prevention nurse. Staff were expected to use hand sanitizer or wash their hands every time they removed their gloves. Additionally, staff should put a barrier between the floor and the graduate every time they drain a catheter bag to prevent splashing on the floor.</p> <p>During an interview on 4/9/25 at 10:18 a.m., licensed practical nurse (LPN)-A stated staff were expected to wash their hands every time they took off their gloves and to put a barrier between the graduate and the floor, like a paper towel, in case of splashing.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/9/25 at 10:23 a.m., LPN-B stated staff were expected to wash their hands after taking off their gloves and to put something underneath the graduate. The facility had disposable underpads to lay down on the floor then put the graduate on top of that.</p> <p>During an interview on 4/9/25 at 10:24 a.m., RN-C stated staff were expected to either use hand sanitizer or wash their hand when they removed their gloves. When doing catheter care staff should lay down something like a disposable underpad, something that will soak up urine and not allow the urine to soil the floor.</p> <p>During an interview on 4/9/25 at 1:02 p.m., the director of nursing (DON) stated staff should put down a disposable underpad as a barrier on the floor when emptying a catheter. Staff were also expected to follow enhanced barrier precautions. Double gloving was unacceptable. Staff were expected to put on a single pair of gloves, wash their hands or use hand sanitizer after removing and then put on a new pair of gloves to prevent potential infection.</p> <p>During an interview on 4/9/25 at 1:09 p.m., the assistant administrator stated staff were expected to follow policy and procedure to ensure the safety of the residents and staff.</p> <p>The facility policy Hand Hygiene/Handwashing undated, identified all staff should practice proper hand hygiene to prevent the spread of infection. Staff were directed to perform hand hygiene in the following situations:</p> <ul style="list-style-type: none"> - Before direct resident contact. - After contact with residents' intact skin. - After contact with body fluids or excretions, mucous membranes or non-intact skin, and wound dressings if hands were not visibly soiled. - After removing gloves. <p>The facility policy Indwelling Urinary Catheter: Use, Insertion Care and Maintenance dated 3/20/24, identified staff were directed to use Enhanced Barrier Precautions (EBP)-don gloves and gown, during any manipulation of the catheter or drainage system.</p> <p>The facility policy Enhanced Barrier Precautions - EBP undated, identified Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:</p> <ul style="list-style-type: none"> - Dressing - Bathing/showering - Transferring <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Providing hygiene - Changing linens - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator - Wound care: any skin opening requiring a dressing

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were consistently implemented in accordance with Centers for Disease Control (CDC) recommendations to reduce the risk of infection for 1 of 4 residents (R31); and failed to ensure appropriate hand hygiene was completed during provision of personal care for 1 of 4 residents (R8) whose cares were observed.</p> <p>Findings include:</p> <p>R31's quarterly Minimum Data Set (MDS) dated [DATE], identified R31 was cognitively intact and required assistance with activities of daily living.</p> <p>R31's care plan, printed 4/9/25, identified all R31's actual or potential problems along with interventions to help R31 meet established goals of care. The care plan outlined R31 was on enhanced barrier precautions (EBP) due to positive for vancomycin-resistant enterococci (VRE) infection in urine. Staff were directed to wear PPE of gloves, gown and face protection if performing activity with a high risk of splash and during high contact resident care activities such as dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care.</p> <p>On 4/7/25, at 4:00 p.m. R31's room was observed from the hallway which had an orange colored sign posted on the middle of the door which read [STOP SIGN] Enhanced Barrier Precautions [STOP SIGN] . Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities . Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assistance with toileting . Across the hall was a hard plastic cart with gowns and other PPE supplies inside.</p> <p>On 4/7/25, at 5:08 p.m. R31 was observed in a half way seated position on the edge of her bed. The room call light was on and R31 stated she wanted assistance to get into her wheelchair. Registered nurse (RN)-A and nursing assistant (NA)-A entered the room and approached the bed to assist R31 into her wheelchair. Neither of the staff had a gown on as directed by the signage. RN-A positioned a gait belt around R31's waist and both staff assisted R31 to a semi stand position and slowly seated her in her wheelchair. R31 then requested assistance to use the toilet. Another nursing assistant (NA)-B entered R31's room to assist with R31's care and RN-A removed her gloves, applied alcohol-based hand rub (ABHR) to her hands and exited the room. NA-B was not wearing a gown as directed by the signage on R31's door. NA-B stated R31 was care planned to have two staff present with care at all times. NA-A wheeled R31 into her bathroom and assisted her onto the toilet after lowering R31's pants and brief. When R31 was finished, NA-A donned gloves and assisted R31 back into her wheelchair. NA-A's uniform was observed brushing against R31 body several times as she was assisting her with toileting and transfer. NA-B stated she was not sure why R31 was on EBP and would have to check with the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 4/7/25, at 5:15 p.m. NA-A stated staff were notified which residents required EBP during shift report, however, she had not attended the full shift report because she had to assist floor staff with a resident's care. NA-A stated she had forgotten to put on PPE when she had assisted R31 with transfer and toileting.</p> <p>When interviewed on 4/7/25, at 5:15 p.m. RN-A stated R31 had bacterial colonization in her urine and they all should have been wearing PPE gowns when they had helped R31 to transfer and toilet.</p> <p>During interview on 4/8/25, at 3:46 p.m. RN-B verified she was also the facility's infection control preventionist and stated any residents with a draining wound, invasive device like a foley catheter or a history of MDRO would be placed on EBP. Staff knew which residents required EBP because of the signage on the resident's door. R31 had been on EBP since her admission. Staff should have stopped when R31 requested assistance with toileting and donned gown and gloves prior to assisting her, even with the initial transfer from her bed to her wheelchair.</p> <p>When interviewed on 4/9/25, at 9:40 a.m. the director of nursing (DON) stated staff should wear PPE of gown and gloves when assisting R31 to transfer or with cares such as toileting. R31 had resistive bacteria in her urine and the PPE was required with any transfers or assistance with cares to reduce the risk of spread of infection. It was required for staff to don a gown for transfers and personal cares, including toileting and staff had been educated on the facility's policy for EBP.</p> <p>The facility's undated policy Enhanced Barrier Precautions-EBP identified EBP was an infection control intervention designed to reduce transmission of multidrug-resistant (MDROs) in nursing homes. Nursing home residents with wounds that required a dressing, an indwelling medical device, and/or residents with MDRO infection or colonization would require EBP. Gown and gloves were required during high contact resident care activities. Examples of high contact resident care activities which required gown and glove use of EBP included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device or wound care.</p> <p>A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, . expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities . residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care.</p> <p>40943</p> <p>R8's quarterly MDS dated [DATE], identified a severe cognitive impairment and diagnoses that included dementia, muscle weakness, and type 2 diabetes. R8 was non-ambulatory and was dependent on staff for all care areas.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R8's care plan dated 3/28/20, identified R8 had an ADL self-care performance deficit related to impaired balance, unsteady gait, limited range of motion, musculoskeletal impairment, right lower leg/foot fracture and non-weight bearing status. Staff were directed to provide: BED MOBILITY: R8 used (1/2 rails on bed) to maximize independence with turning and repositioning in bed; DRESSING: R8 required (extensive assistance) by (1) staff to dress to pull on/off socks, lace up right foot brace and pants; PERSONAL HYGIENE: R8 required (extensive assistance) by (1) staff with personal hygiene and oral care to clean full upper denture and comb back of hair; TOILET USE: Transfer on/off toilet or commode with total body mechanical lift with 2 staff. Due to inability to consistently bear weight for transfers; and TRANSFER: Total body mechanical lift with 2 staff for all transfers. Needs to wear shoes during transfers.</p> <p>During an observation on 4/9/25 at 7:24 a.m., nursing assistant (NA)-D entered R8's room to provide morning cares.</p> <p>- At 7:29 a.m., NA-D put on gloves and explained to R8 she needed to check R8's incontinence brief. NA-D checked R8's brief and stated a new would need to be put on because the brief was soiled with urine. NA-D did remove her gloves and washed R8's face with a disposable washcloth. NA-D removed R8's incontinence brief and used a disposable washcloth to clean urine and feces from R8's skin.</p> <p>- At 7:34 a.m., NA-E entered the room and obtained a clean brief for NA-D. NA-D removed her gloves but did not wash her hands or use hand sanitizer before putting on new gloves. NA-D assisted R8 to put on the clean brief.</p> <p>- At 7:39 a.m., NA-D and NA-E assisted R8 to wash her upper body, put on deodorant and dress. R8 was then assisted into her wheelchair with a full body mechanical lift.</p> <p>- At 7:56 a.m., NA-D removed her soiled gloves and assisted R8 to breakfast. NA-D did not wash her hands or use hand sanitizer.</p> <p>During an interview on 4/9/25 at 7:58 a.m., NA-D stated you should use hand sanitizer whenever removing gloves, especially after cleaning feces. It's feces and you don't want to spread that anywhere else.</p> <p>During an interview on 4/9/25 at 10:02 a.m., registered nurse (RN)-B stated she was the facility infection prevention nurse. Staff were expected to use hand sanitizer or wash their hands every time they removed their gloves.</p> <p>During an interview on 4/9/25 at 10:18 a.m., licensed practical nurse (LPN)-A stated staff were expected to wash their hands every time they took off their gloves.</p> <p>During an interview on 4/9/25 at 10:23 a.m., LPN-B stated staff were expected to wash their hands after taking off their gloves.</p> <p>During an interview on 4/9/25 at 10:24 a.m., RN-C stated staff were expected to either use hand sanitizer or wash their hand when they removed their gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/9/25 at 1:02 p.m., DON stated staff were expected to put on a single pair of gloves, wash their hands or use hand sanitizer after removing and then put on a new pair of gloves to prevent potential infection.</p> <p>During an interview on 4/9/25 at 1:09 p.m., the assistant administrator stated staff were expected to follow policy and procedure to ensure the safety of the residents and staff.</p> <p>The facility policy Hand Hygiene/Handwashing undated, identified all staff should practice proper hand hygiene to prevent the spread of infection. Staff were directed to perform hand hygiene in the following situations:</p> <ul style="list-style-type: none"> - Before direct resident contact. - After contact with residents' intact skin. - After contact with body fluids or excretions, mucous membranes or non-intact skin, and wound dressings if hands were not visibly soiled. - After removing gloves.