

State law requires facilities to confirm adverse events with the Department of Health when they occur. (<u>RCW</u> <u>70.56.020</u>) The facility must notify the department within 48 hours of confirming an event. Notification includes date, type of adverse event, and facility contact information. Facilities may also include contextual information regarding the reported event by completing and submitting this form. This form is optional and not required as part of the reporting requirements.

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- Email to: <u>AdverseEventReporting@doh.wa.gov</u>, or
- Mall to: DOH Adverse Events, PO Box 47853, Olympia, WA, 98504-7853, or
- Fax to: Adverse Events (360) 236-2830

Facility Name:	Kindred Hospital Seattle
Facility Contact:	Ryan Hosken (Director of Quality)
Facility web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
Date of Event Confirmation:	1/10/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50
Other Facility Information:	LTAC
Event Information:	Patient A was assessed as having sacrum/left buttock/coccyx deep tissue injuries (DTIs) present on admission patient was admitted 1/2/2020
	Per 1/10/2020 note at 1946 – three separate DTIs have demarcated and present as one Stage 3 wound – DQM notified on 1/14/2020 at 0930
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Ryan Hosken (Director of Quality)
https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
1/14/2020
50
LTAC
Patient B was assessed as having sacrococcygeal pressure injury noted to have evolved to unstageable on 1/14/2020 patient was admitted on 12/24/2019 with Stage 2 pressure injury to sacrum/coccyx present on admission



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Facility web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
Date of Event Confirmation:	1/21/2020 (pertaining to two patients and two event reports)
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50
Other Facility information:	LTAÇ
	4F event reported on 1/21/2020:
	Patient C was assessed as having an abrasion on the right heel that was present on admission. This abrasion was reported to have evolved to a Stage 3 as of today (1/21/2020). Patient was admitted 1/6/2020.
	Patient C was also assessed as having a Stage 3 sacral wound that was present on admission (1/6/2020). The sacral wound was reported to have progressed to unstableable (worsened) as of today (1/21/2020).
	4F event reported on 1/21/2020:
	Patient D was assessed as having a Stage 2 sacral wound (not presented on admission) that progressed to two separate pressure injuries, a stage 3 and an unstageable wound, both on the patient's sacrum. Patient was admitted 9/1/2019.



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Facility Name:	East Adams Rural Heathcare
Facility Contact:	Jennifer Peppend
Facility web site:	EARH.org
Date of Event Confirmation:	1-25.20
Facility capacity: (e.g., # of beds, rooms, procedures per year)	12 beds.
Other Facility Information:	
Event Information:	A resident makeuas found to have,
	his hand up another females
	shirt. This occurred after
	the noon meal on 1/as/ao.
	This was witnessed by the
	change nurse. Male resident removed
	his hand when she came
	in divining noom, female resident
	removed charge nurse talked to
	her one did not state anything.
	assment dore. Nothing found.
	resident on alert charking.



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Facility Name:	Kindred Hospital Seattle
Facility Contact:	Ryan Hosken (Director of Quality)
Facility web site:	https://www.kindredheallhcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
Date of Event Confirmation:	1/31/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	
Other Facility Information:	LTAC
Event Information:	4F event reported on 1/31/2020:
	Patient F was assessed as having a deep tissue pressure injury (DTPI) to the left ischial tuberosity on 1/4/2020. The DTPI to the left ischium was reported to have evolved to a Stage 3 as of 1/31/2020. Patient was admitted 12/21/2019.



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Facility Contact:	Ryan Hosken (Director of Quality)
Facility web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
Date of Event Confirmation:	2/3/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	60
Other Facility information:	LTAC
Event Information:	4F event reported on 2/6/2020
	4F event on 2/3/2020
	Patient G was assessed as having unstageable pressure injuries to the right and left sides of his forehead on 2/3/2020, as well as a stage 3 sacral pressure injury on 2/3/2020, Delayed reporting due to clarification of stages (2 vs 3/unst). Patient was admitted 1/28/2020.
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Facility Contact:	Ryan Hosken (Director of Quality)
Facility web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
Date of Event Confirmation:	2/4/2020 (x3) and 2/6/2020 (x1)
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50 .
Other Facility information:	LTAC
Event Information:	Additional 4F events reported on 2/6/2020
Ever moundaton.	4F event(s) on 2/4/2020
	Patient H was assessed as having a stage 3 pressure injury to lower mid-back on
	Patient I was assessed as having right heel wound that resolved from stage 4 on 6/9/2019 (previously reported) to stage 2 prior to an infection noted on 2/4/2020 making the pressure injury unstageable (worsened). Patient was admitted 2/15/2019.
	Patient D2 was assessed as having a stage 3 pressure injury to coccyx on 1/21/2020 (previously reported) that has advanced to unstageable (worsened). Area of redness to coccyx noted 9/1/2019. Patient was admitted 8/21/2019.
	4F event on 2/6/2020
	Patient E2 was assessed as having a deep tissue pressure injury (DTPI) to right heel initially assessed on 1/24/2020 noted as unstageable on 2/6/2020. The DTPI to the right hip was reported to have evolved to stage 3 as of 1/29/2020 (previously reported). An adjacent pressure injury (right greater trochanter area of right hip) was noted on 2/6/2020 as unstageable. Patient admitted with multiple pressure injuries and surgical sites on 12/22/2019.
	Note: As in 2019, patients will be reported as A through Z based on date of 4F event. A number will follow if the patient was previously reported in 2020. Patients reported in 2019 or not previously reported will be assigned a new letter (A-Z).



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Facility Name:	Newport Hospital & Health Services
Facility Contact:	Lynn A. "Pete" Peterson, MSN, RN, CRNA
Facility web site:	https://newporthospitalandhealth.org
Date of Event Confirmation:	02/06/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	Critical Assess Hospital (Less than 25 beds)
Other Facility Information:	
Event Information:	Felt that this is a moderate injury but initiated simple RCA review with staff.
	Patient Discharge Home without incident.
	70yo female severe anemia and cardia demand ischemia
	Patient fall on 2-06-2020,
	Johns Hopkins Hospital Adult Fall Assessment Tool of Low (5).
	Fall Prevention in place prior to fall:
	Bed in low position, Bed Brake on, Educated to use call light, Call Light in reach, Curtains open, door to room open.
	Fall: 2-06-202 @ 2245
	Post Fall Evaluation: Emergency Department Physician evaluation and ordered CT Head reported at 0227
	Findings: (1) Minimal trace subarachnoid hemorrhage
	Patient put on q1h neuro checks throughout the night.
, ,	Palients only c/o headache
	No other associated issue or complications,



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>:	Kindred Hospilal Seattle
Facility Name:	* •
Facility Contact:	Ryan Hosken (Director of Quality)
Facílity web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seatlle-first-hill
Date of Event Confirmation:	2/6/2020 and 2/7/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50
Other Facility Information:	LTAC
Event Information:	4F events reported on 2/8/2020
	4F event on 2/6/2020
	Palient J was assessed as having an unstageable (vs stage 2) pressure injury to the left thigh likely related to Foley tubing on 2/6/2020. Patient was admitted 1/14/2020.
	4F event on 2/7/2020
	Patient K was assessed as having a deep tissue pressure injury (DTPI) to the sacrum which was noted to have evolved to stage 3 on 2/7/2020. Patient was admitted 1/16/2020.
	Note: Our next aggregate RCA is scheduled for submission on 2/24/2020. Kindred Seattle Hospital is addressing some inter-rater variation in staging for identified and reported 4F events by establishing a process of peer-review for concurrence. However, to meet our 48-hour window for reporting, all potential events will be reported (though some may be retracted later).



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Facility Contact:	Ryan Hosken (Director of Quality)
Facility web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
Date of Event Confirmation:	2/13/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	60
Other Facility Information:	LTAC
Event Information:	4F event reported on 2/13/2020:
	Patient F2 was assessed as having a deep tissue pressure injury (DTPI) to the left ischial tuberosity on 1/4/2020. The DTPI to the left ischlum was reported to have evolved to a slage 3 as of 1/31/2020. This same wound was reported to have evolved to stage 4 on 2/13/2020. Patient was also noted to have a stage 3 pressure injury to the trochanter of the left hip on 2/13/2020. Patient was admitted 12/21/2019.

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#### Adverse Event Contextual Information Form (Optional)

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Facility Name:	Kindred Hospital Seattle
Facility Confact:	Ryan Hosken (Director of Quality)
Facility web site;	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
Date of Event Confirmation:	2/19/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50
Other Facility information:	LTAC
Event Information:	4F event reported on 2/19/2020
	Patient M was assessed as having stage 2 pressure injuries to the right and left buttocks that were present on admission. The left buttock wound was noted to have progressed to stage 3 as of 2/19/2020. Patient was admitted on 1/28/2020.
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Facility Contact:	Ryan Hosken (Director of Quality)
Facility web site:	https://www.kindredheallhcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
Date of Event Confirmation:	3/6/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50
Other Facility information:	LTAC
Event Information:	4F event on 3/6/2020 - reported on 3/8/2020
	Patient O was assessed as having a sacral wound noted to have progressed to unstageable on 3/6/2020. Patient was admitted on 2/19/2020.



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Facility web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
Date of Event Confirmation:	3/7/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50
Other Facility information:	LTAC
Event Information:	4F event on 3/7/2020 - reported on 3/9/2020
	Patient L2 was assessed as having a stage 2 pressure injury to the sacrum on 2/28/2020 that worsened to unstageable on 3/7/2020. Patient is able to turn, but is non-compliant. Patient was admitted on 2/1/2020, returned to STAC on 2/22/2020, and was readmitted on 2/28/2020 with stage 2 sacral wound (now unstageable).
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Facility Contact:	Ryan Hosken (Director of Quality)
Facility web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
Date of Event Confirmation:	3/21/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50
Other Facility information:	LTAC
Event Information:	4F event on 3/21/2020 - reported on 3/23/2020
	Patient L3 was assessed as having an unstageable pressure injury to the left ischial tuberosity (adjacent to the unstageable sacral wound). Per the report on Patient L2 (same patient) the patient is able to turn and continues to be non-compliant despite education and encouragement. Patient was admitted on 2/1/2020, returned to STAC on 2/22/2020, and was readmitted on 2/28/2020.

### Washington State Department of Health

### Adverse Event Contextual Information Form (Optional)

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Complete the following information and return by:

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- Fax to: Adverse Events (360) 236-2830

Kindred Hospital Seattle
Ryan Hosken (Director of Quality)
https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred- hospital-seattle-first-hill
3/28/2020
50
LTAC
4F event on 3/28/2020 (reported on 3/30/2020):
Patient P was assessed as having a new unstageable pressury injury to the right occiput on 3/28/2020. Patient was admitted on 3/14/2020.

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Facility Name:	St Joseph Medical Center
Facility Contact:	Crystal Collins
Facility web site:	253-426-6239
Date of Event Confirmation:	April 9, 2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	370 beds
Other Facility information:	
<u>Event</u> Information:	An unstageable HAPI was identified via the coding review process after the pt was discharged. Upon further review by our wound therapy experts, this wound was miscoded as a HAPI and was actually a diabetic foot ulcer. As such, it should not have been reported as a HAPI.



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Facility Name:	Cascade Valley Hospital, Part of Skagit Regional Health
Facility Contact:	Sarah Place
Facility web site:	https://www.skagitregionalhealth.org/
Date of Event Confirmation:	5/21/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	48 bed acute care hospital
Other Facility information:	
Event Information:	Cascade Valley Hospital had a patient who was admitted on October 18, 2019, and later died on October 22, 2019. The hospital filed a police report on the case for investigation due to report of suspicious visitor on October 21, 2019.
	When the patient arrived at CVH, his clinical picture included the following:
	Acute respiratory failure with hypoxia Pneumonia Sepsis
	Acute Myeloid Leukemia, not having achieved remission Transaminitis NSTEMI
	Several consults were obtained and the patient was determined to not be a candidate for additional interventions, specifically leukopheresis or interventional cardiology.
	Patient had a visitor on the evening of 10/21/2019. Patient status deteriorated sometime shortly after visitor departed. Later in the evening, what appeared to be two puncture marks were found on the patients arm and were noted to be bleeding and the patient deteriorated shortly thereafter and was intubated.
	Lab work was performed and patient was found to be positive for methamphetamine. Patient only admitted to using marijuana and drinking beer at admission. Police investigation identified he was a known addict and distributor of illegal drugs to include methamphetamine and heroin.
	Family were notified of patient's condition and determined that he should be taken

Washington State Department of	Adverse Event Contextual Information Form (Optional)
<b>A</b> Health	off of life support. The patient died shortly after being extubated.
	Given the concern about the positive methamphetamine lab result, suspicious visitor and location of puncture marks, we made an immediate report to the police. Our report to the Department of Health was awaiting confirmation of the investigation findings. We received the report on May 20, 2020.
	The decision to report this of the case was not made until now as there was a prolonged investigation of 5 months. The report had an indication of the offense being categorized as Controlled Substance – Homicide. The police are not pursuing prosecution.
	We do not know all the facts despite extensive investigation and are reporting this case to DOH out of an abundance of caution.
	The police investigation report is available for review.



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Facility Name:	Center for Birth
Facility Contact:	Tina Tsiakalis
Facility web site:	www.centerforbirth.com
Date of Event Confirmation:	05/27/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	3 birth suites
Other Facility information:	Free-standing birth center
Event Information:	Event was a very rare complication of the 3 <sup>rd</sup> stage of labor. Client experienced an inversion of her uterus with delivery of placenta, and associated hemorrhage. She had an unremarkable pregnancy and a vaginal birth at the birth center on 5/27/2020.
	She was transported to the University of WA Medical center by paramedics, where she received treatment and was discharged the following day, approximately 33 hours after arriving.
	She is doing well, and her baby is thriving.



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Facility Name:	St. Luke's Rehabilitation Institute
Facility Contact:	Rhonda Stowe
Facility web site:	St. Luke's Rehabilitation Institute.org
Date of Event Confirmation:	6/9/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	102 licensed beds
Other Facility information:	Inpatient Rehabilitation
Event Information:	85 yo female, independent and preparing for discharge home. Ambulating with therapist at faster pace than usual. Therapist attempted to slow patient down and was unsuccessful. Patient fell on outstretched arm and sustained non displaced fracture. All policies and protocols for fall risk were followed.



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<b>F</b> 114 - N1 - · · · ·	Navos Children's Residential Program
Facility Name:	÷
Facility Contact:	Elizabeth Thompson, Sr. Quality and Compliance Manager
Facility web site:	www.navos.org
Date of Event Confirmation:	7/3/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	34
Other Facility information:	Navos – Lake Burien Campus 1035 SW 152 <sup>nd</sup> St / 1031 SW 152 <sup>nd</sup> St / 1027 SW 152 <sup>ND</sup> ST Burien, WA 98166-1845
Event Information:	At approx. 20:04, on 7/3/20, resident 1 (male, 16yrs.) used towels to appear he was in bed asleep. He was in hall, telling staff he was asked to switch bathrooms due to cleaning, and subsequently was allowed entry to a bathroom. Staff assumed resident 1 had finished his shower and was heading to bed when seen in hallway.
	At 20:19 resident 2 (female, 13 yrs.) requested to shower, and when offered one bathroom, requested the bathroom that resident 1 had been in. To confirm resident 1 was not in that bathroom, staff viewed resident 1 in his bed. Resident 2 was then allowed in the bathroom requested.
	At 20:27 staff realized that the sleeping resident was in fact the towels set up to mimic a sleeping person. Staff knocked on bathroom door and requested that resident 2 come out with their clothes on. When resident 2 exited the bathroom she offered that they (Resident 1/Resident 2) were in bathroom "having sex".
	Staff entered bathroom and found resident 1 fully clothed. Staff report that residents were alone in the bathroom for 11 minutes. Both residents admit sexual contact.
	Management immediately notified. By 23:30, Burien Police Department Case# L20021002. CPS and Guardians were notified, with extensive communications following.
	Resident 2 transported to Seattle Children's ER for labs, medication and a SANE evaluation. Resident 2 returned to campus at 7am, 7/4/20.
	Resident 1 was moved to a separate cottage, away from resident 2.
	RCA and plan of correction to follow within 45 days of this notification.
	L



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Facility Name:	University of Washington Medical Center
Facility Contact:	Lisa Robinson, Manager of Clinical Regulatory Compliance
Facility web site:	www.uwmedicine.org
Date of Event Confirmation:	9/24/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	
Other Facility information:	
Event Information:	Event 7C: Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting reported 9/24/2020. Sexual assault of a staff member by a patient.



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Facility Name:	SURGERY CENTER OF SILVERDALE, LLC
Facility Contact:	BLAKE REITER MD
Facility web site:	SILVERDALEASC. COM
Date of Event Confirmation:	
Facility capacity: (e.g., # of beds, rooms, procedures per year)	3 OR, ~2500 sungery/4r.
Other Facility information:	
Event Information:	notified by Kaiser late \$100 of "event"- notified of went by Kaiser (name) 10/2 - notified by Kaisen 10/6 to 4:52 pm that they were not reporting pt had catonact surgery E IOL placed, surgery here on connect a ye and lens im plant (IOL) im planted was connect as fan as lens that was ordered - lens was inconnectly identified on order sheet from Kaiser - rhere was a transcription error from biometric data to order sheet that was then sent to om facility - proper precontions was followed @ facility to insure that the ordered luns was implanted - wrong lens implanted kut because wrong lens had been ordered - lens ultimately replaced - proper

Office of Community Health Systems DOH 530-106 (March 2011)



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Facility Name:	Northwest Orthopaedic Specialists
Facility Contact:	Quinanna Robins, CEO
Facility web site:	http://www.nworthopaedicspecialists.com/
Date of Event Confirmation:	10/15/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	5 Operating Rooms, 2 Procedure Rooms, Approximately 12,000 cases a year
Other Facility information:	
Event Information:	The patient was marked and consented at the bedside by surgeon. The anesthesiologist then came out to perform a block in the pre-op area. The time out was done, however, the mark was not visualized by the nurse or anesthesiologists. The time out was read aloud and anesthesiologist, RN and patient all agreed it was the left side. Anesthesiologist blocked the right knee. It appears that the time out was incomplete and the mark not visualized by the team. A Root Cause Analysis will be submitted within 45 days.



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Facility Name:	Cascade Valley Hospital
Facility Contact:	Lisa Norton
Facility web site:	www.skagitregionalhealth.org
Date of Event Confirmation:	10/26/2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	48 Beds
Other Facility information:	Cascade Valley Hospital is a 48 bed acute care facility in Arlington, Washington. CVH is part of the Skagit Regional Health system.
Event Information:	On Saturday morning, 10/24/2020, a pregnant patient who had been laboring after a SROM, was being monitored when a significant change to the fetal heart rate was noted. A stat C-Section was performed, however, the fetus was stillborn.
	The pregnancy was noted to be a monoamniotic monochorionic twin gestation. Mother had SAB of 2 <sup>nd</sup> fetus in 1 <sup>st</sup> trimester.
	Autopsy has been requested.
	At this point in time, we do not know all the facts and are reporting pending further findings.



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Facility Name:	Western Washington Medical Group. Inc DBA: Guteway
Facility Contact:	Kathlin Sullivan Surgary Center
Facility web site:	<i>n</i> - <i>f</i>
Date of Event Confirmation:	Nov 23, 2020
Facility capacity: (e.g., # of beds, rooms, procedures per year)	2 Bed OR
Other Facility information:	
Event Information:	On Nov 23, 2020 two patients, Were given the incorrect nucleation resulting in transfors to Providence Everett, Juritha Cardiac and in patient stay required. Nov 25, 2020