Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 7, 2017	2017_643111_0015	014846-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE HALIBURTON
167 PARK STREET P.O. BOX780 HALIBURTON ON K0M 1S0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LYNDA BROWN (111), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 16 to 20, 2017

The following critical incidents were inspected concurrently during this RQI:
-Log # 010244-17 related to a fall resulting in injury.
-Log # 016533-17 & 018272-17 related to alleged resident to resident abuse.

The following complaints were also inspected concurrently during this RQI:
-Log # 008008-17 related to an injury of unknown cause.
-Log # 018948-17 related to falls, incontinence and bowel management.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), the Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Physiotherapy Assistant (PTA), residents, families, Resident Council President and Family Council representative.

During the course of the inspection, the inspector(s) toured the home, observed a medication administration, reviewed the home's investigations, complaints, reviewed resident health records, reviewed resident council meeting minutes, and reviewed the following licensee policies: Prevention of Abuse and Neglect, Complaints and Falls Prevention.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that written plan of care set out the planned care for the resident in relation to the use of bed rails.

On a specified date, resident #007 and resident #011 were observed by Inspector #570 in bed with two bed rails kept in guard position.

On two specified dates, during interviews with Inspector #570, RN #107, RPN #103 and PSW #108 all indicated that resident #007 and resident #011 did not have any restraints and they used two bed rails for bed mobility.

Review of the current plan of care for resident #007 and #011 with RN #107 and RPN #103, both confirmed to Inspector #570 that use of bed rails by resident #007 was not included in the plan of care.

On a specified date, during an interview with Inspector #570, the ADOC indicated that the plan of care for resident #007 and #011 should have included the use of bed rails and the intent for using the rails. [s. 6. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a written plan of care that sets out the planned care for residents related to the use of side rails, and that the plan of care is based on an assessment of the resident's needs and preferences, specifically related to pain management, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when resident #025 complained of pain, the resident was assessed for pain using a clinically appropriate assessment instrument specifically designed for this purpose

Related to Compliant Log #008008-17:

Review of clinical records for resident #025 indicated the resident presented with an injury to a specified area on a specified date and had a confirmed diagnosis of injury to the specified area approximately three weeks later. Review of the resident's progress notes indicated the following: on a specified date and time, the resident was awake and yelling out. Approximately four hours later, the resident was noted to have an injury to a specified area, complained of pain, but unable to indicate how the injury occurred. Alternative pain management was offered but refused. Two hours later, the physician assessed the resident and ordered a diagnostic test to the specified area and a mobilizing medical device to the area. The following day, the residents injury to the specified area progressed and was placed on bed rest. The resident complained of pain

on movement. The resident was not provided analgesic until the evening. The following day, the resident's bath was held due to continued pain to the specified area. No analgesic was provided. The following day, the mobilizing medical device was applied and the resident was no longer on bed rest. Four days later, the resident was assessed again by the physician and indicated the injury remained to the specified area, the resident continued to complain of pain with movement but the diagnostic test was negative for injury. The physician ordered a second diagnostic test. Later that evening the resident was provided with analgesic. Approximately 2 weeks later, the resident complained of pain to the specified area but was not provided analgesic. Six days later, a second diagnostic test confirmed a specified injuries to the specified area.

Review of the resident #025's plan of care (at time of incident) directed staff to monitor resident #025 for acute changes in condition and attempt to determine underlying causes (i.e. pain). The plan of care was revised approximately four weeks later and indicated injuries to specified area, directed staff to encourage the resident to use mobilizing medical device. The plan of care did not address the resident's pain to the specified area, pharmaceutical interventions, or any assessments to be completed related to pain.

On a specified date, during separate interviews, RN #110 and RPN #100 with Inspector #571, both confirmed that resident #025 had no pain assessment completed when the resident complained of pain to a specified area and the resident did not receive any PRN pain medication on specified dates. They both further indicated that the resident should have been assessed for pain and should have received PRN pain medication when pain was reported.

On a specified date, during an interview with the ADOC, indicated to inspector #570, that resident #025 did not receive any analgesic on the day the resident complained of pain to a specified area and no pain assessment was completed. The DOC indicated that the expectation is that pain assessments were to be completed but it was not done for resident #025.

Review of Medication Administrator Records (MARs) for a specified month for resident #025 indicated the resident did not receive any pain medication on specified dates that the resident complained of pain to specified area or when a diagnostic test confirmed the resident sustained an injury to a specified area.

Record review and staff interviews indicated resident #025 was not assessed for pain using a clinically appropriate instrument specifically designed for this purpose. In

addition, when the resident demonstrated ongoing pain, complained of pain to a specified area on specified dates, had injury to the specified area, the registered nursing staff on those specified dates, did not provide the resident with analgesia. There was also no pain assessment completed when the resident complained of pain or when the resident had a confirmed diagnosis of an injury to the specified area. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when residents complain of pain, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to log # 016533-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident sexual abuse incident. The CIR indicated five days earlier, at a specified time, resident #022 reported that resident #021 was involved in the allegation. An after-hours call was received on the day the incident was reported. There was no indication the police were notified.

Review of the progress notes for resident #022 indicated on a specified date, the resident reported the alleged sexual abuse incident to RPN # 115 and RN #114. RPN #115 & RN #114 both reported the allegation to the DOC the same day at specified times.

Interview with the DOC on a specified date, by Inspector #111, indicated she did not call the police because resident #022 did not want her to call the police. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the appropriate police force is immediately notified of any alleged, suspected or witnessed incidents of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee failed to ensure that a verbal complaint made to the licensee or a staff member concerning the care of resident #022 was immediately investigated and resolved where possible, and a response was provided to the person who made the complaint, within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief.

Related to log # 016533-17:

Review of the progress notes for resident #022 indicated on a specified date and time, the resident reported an alleged resident to resident sexual abuse that occurred at a specified time by resident #021 to RPN #115. A specified action was taken by the home to prevent a recurrence. The following day at a specified time, the resident reported to RPN #115 overhearing staff discussing the specified action taken to prevent a re-

occurrence and was said in an inappropriate manner which resulted in the resident being upset.

Telephone interview with RPN #115 on a specified date, by Inspector #111, confirmed resident #022 reported overhearing staff speaking inappropriately about the resident and was upset as a result. The RPN indicated she reported the resident's verbal complaint to the SDM but did not report the complaint to the RN or the DOC. The RPN was unaware of the complaint investigation form that was to be used for any complaints received in the home.

Interview with resident #022 on a specified date, by Inspector #111, indicated the ADOC came to see the resident after the allegations were made and actions taken to prevent a recurrence, to ensure the resident was satisfied with the outcome. The resident indicated that was when the ADOC was informed of the residents verbal complaint about staff speaking inappropriately about the resident. The resident was not satisfied with the ADOC's response to the verbal complaint.

Review of the licensee's complaint log for 2017 had no documented evidence of the verbal complaint received by resident #022.

Interview with ADOC by Inspector #111 indicated she had no documented investigation into the verbal complaint received and confirmed the complaint was not indicated on the complaint log.

Interview with the DOC on a specified date by Inspector #111, indicated awareness of resident #022 verbal complaint received on a specified date but did not investigate or document the complaint. [s. 101. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident was dealt with in accordance to O.Reg.79/10, s. 101(1), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and

maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of the medication incident reports for a three month period indicated their were nine medication incidents involving residents as follows:
- the first medication incident occurred on a specified date, involved resident #001 and the resident received an extra dose of narcotic analgesic. The incident report was completed by the ADOC seven days later, despite the incident being discovered five days prior (during the narcotic count at shift change). There was no indication the medical director was notified and the resident's progress notes had no documented evidence of the medication incident. Review of the Medication Administration Record (MAR) for the specified date indicated both RPN #103 and RPN #115 discovered the missing narcotic. The MAR indicated both RN #114 and RPN #116 administered the narcotic on the specified date but it was not clear which staff member was involved in the medication incident. Interview with the ADOC by Inspector #111 on a specified date indicated she could not indicate why the medication incident was not reported when the medication incident was discovered, or which registered staff were involved in the incident. The ADOC also indicated there should have been a progress note completed indicating the resident was assessed. The ADOC also indicated no documented evidence of actions taken regarding this medication incident and indicated RPN # 116 was directly involved in the incident but no longer worked in the home.
-the second medication incident occurred on a specified date and time, involved resident #026 and the resident reported being in pain due to not receiving a narcotic analgesic as prescribed. The medication incident was discovered by RN #107 when the RN noted the narcotic was signed as given on the MAR but noted at the narcotic count the medication was not given by the same RN. There was a progress note regarding the medication incident but no indication the resident was given the medication when the error was discovered, despite being in pain. There was no indication the Physician, family or Medical Director were not notified.
-the third medication incident occurred the following month on a specified date and time, involved resident # 027 and was not administered an antidepressant as prescribed. The incident was discovered by RPN #100 but the incident report was not completed until two days later. There was no indication the family, Physician, or Medical Director was notified of the medication incident. Review of the MAR indicated RPN #103 was involved in the incident. There was no progress note regarding the medication incident to indicate the

resident was assessed or actions taken.
-the fourth incident occurred on a specified date and time, involved resident #027 and was not administered a medication used for dementia as prescribed. There was no indication the family, Physician, or Medical Director was notified of the medication incident. Review of the MAR indicated RPN #103 was involved in the incident. There was no progress note regarding the medication incident to indicate the resident was assessed or actions taken.
-the fifth medication incident occurred on a specified date and time, involved resident #027 and was not administered a blood thinner as prescribed. The incident was discovered by RPN #115. There was no indication the family or Medical Director were notified of the medication incident. Review of the MAR indicated RPN #101 was involved in the medication incident. There was no progress note regarding the medication incident to indicate the resident was assessed or actions taken.
-the sixth medication incident occurred on a specified date and times, involved resident #028 and was not administered an analgesic as prescribed. The incident was discovered by RPN #116. There was no indication the family or Medical Director was notified of the medication incident. Review of the MAR indicated RPN #101 was involved in the medication incident.There was no progress note regarding the medication incident or actions taken.
-the seventh incident occurred the following month on a specified date and time, involved resident #029 and was not administered a cardiac medication as prescribed. The medication incident was discovered by RPN #100. There was no indication the family, Physician, or Medical Director was notified of the medication incident. Review of the MAR indicated RPN #101 was involved in the incident. There was no progress note regarding the medication incident or actions taken.
-the eighth medication incident occurred the following month on a specified date and time, involved resident #021 and was not administered an antidepressant as prescribed. There was no indication the family, Physician, or Medical Director was notified of the medication incident. Review of the MAR indicated RPN #117 was involved in the incident. There was no progress note regarding the medication incident to indicate the resident was assessed or actions taken. .
- the last medication incident occurred on a specified date and time, involved resident #015 and was administered an incorrect dose of injectable narcotic analgesic. Review of the MAR indicated RPN #101 was involved in the incident. The progress notes indicated the Physician was contacted when the error was discovered but there was no indication of the dosage the resident actually received. There was no documented record of any follow up action regarding this incident by the ADOC or DOC.

Interview with the ADOC on a specified date by Inspector #111, indicated that any medication incidents should be documented on a medication incident report and in the individual resident chart and should include what occurred, assessment of the resident, and notifying the family and physician. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept.

Review of the medication incidents for a specified time period indicated there were nine medication incidents involving residents. See details under s. 135(1). Seven out of the nine medication incidents involved residents not receiving their medication as prescribed, as the medications were discovered still in the medication cart. There were three separate incidents of resident #027 not receiving their medication as prescribed. There was no corrective action taken when a narcotic was noted missing during the narcotic count on a specified date and the medication incident report was not completed until seven days later by the ADOC. RPN #101 was directly involved in four of the nine medication incidents and RPN #103 was directly involved in two of the nine medication incidents. There was no documented evidence the medication incidents were reviewed and analyzed, or corrective actions taken as necessary.

Interview with the ADOC by Inspector #111 on a specified date, indicated she could not determine why the missing narcotic medication incident that was reported on the date it was discovered (during the narcotic count). The ADOC also indicated no awareness why no other actions were taken (i.e. notify the police or the Director of a missing controlled drug). The ADOC also confirmed there was no documented evidence of corrective actions taken regarding this medication incident. The ADOC indicated RPN # 116 was directly involved in the missing narcotic and no longer worked in the home.

Telephone interview with the DOC on a specified date by Inspector #111, indicated she reviewed all medication incidents with registered staff and documented this on the MedeReport. The DOC was unable to indicate which RPNs were involved in each medication incident or which RPN she followed up with. The DOC indicated no documented evidence to indicate what corrective action was taken for each medication incident. [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents that occurred in the home since the time of the last review in order

to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and a written record was kept.

Review of the quarterly Professional Advisory Committee (PAC) meeting minutes (for two specified months in 2017) had no documented evidence that medication incidents were reviewed for trends or corrective actions.

Interview with the ADOC on a specified date by Inspector #111, indicated she attended the Professional Advisory Committee (PAC) meetings quarterly and they usually discussed medication incidents for the previous quarter but did not at the last two meetings.

Telephone interview with the Administrator/DOC by Inspector #111 indicated that they usually review medication incidents quarterly at the PAC meetings but they did not complete this process at the last two meetings. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; that a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b); (a) quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b)., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council minutes on a specified date by inspector #570, revealed several concerns related to mobility aides cluttering the dining room as an ongoing concern, residents not seated at assigned tables during meal times and unclean drinking glasses. The minute's review also revealed a recommendation to have nourishment served after church service.

Review of the written response dated two days later by the Administrator indicated the Administrator did not address any of the concerns and recommendation brought forward by residents during the meeting on the specified date.

During an interview, on a specified date, the Administrator indicated to Inspector #570, that she becomes aware of any concerns by reviewing the Residents' Council meeting minutes and provides a written response to the council within 10 days. The Administrator confirmed to Inspector #570 that her written response on a specified date did not address the concerns and recommendation brought forward during the Residents' Council meeting. [s. 57. (2)]

Issued on this 7th day of November, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.