Ontario

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 4, 2019	2019_815623_0014	008417-18, 017688-18, 011372-19, 012518-19, 014521-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Thorntonview
186 Thornton Road South OSHAWA ON L1J 5Y2

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

SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 4 - 6, 9 - 13, 16 - 18, 2019

The following logs were inspected concurrently:

Log #017688-18 for Critical Incident Report related to an outbreak
Log #011372-19 for Critical Incident Report related to a fall
Log #012518-19 for Critical Incident Report related to a fall
Log #008417-18 for Critical Incident Report related to alleged staff to resident neglect
Log #014521-19 for Critical Incident Report related to alleged staff to resident abuse

Critical Incident Report (CIR) Inspection #2019_815623_0014 and Complaint Inspection #2019_643111_0018 were inspected concurrently. Non-compliance was identified for complaint log #015679-19 and a similar non-compliance was identified in CIR #2019_815623_0014. A Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c.8, s.20(1) was identified in the inspection report 2019_643111_0018 dated September 4, 2019 which was inspected concurrently with this inspection and will be reflected in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Services Coordinator (RSC), Office Manager, Housekeepers, residents and families.

In addition the Inspectors reviewed clinical medical records, the licensee's internal investigation records and related policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

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

5 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

Related to log #008417-18 for CIR:

A CIR was submitted to the Director on a specified date for an incident of alleged neglect that was reported to Registered Practical Nurse (RPN) #104 on a specified date. The CIR indicated that on an identified date resident #009 was discovered at a specified time in an identified room on an identified home area. The PSW staff began their shift at a specified time and were unaware of how the resident was able to get in to the identified room, as it required a key that only staff would have. The licensee's investigation included viewing the video footage of the home area. The video footage revealed that resident #009 was let in to the identified room by PSW #110 at a specified time, and the PSW did not return before the end of their shift. The resident was in the identified room unaccompanied for an extended period of time.

Review of the written plan of care for resident #009 that was current at the time of the incident, was completed by Inspector #623. The written plan of care identified that resident #009 required specific interventions to assist with toileting. The interventions indicated that the resident required the assistance of staff and had an identified schedule. When the resident was assisted staff were to maintain privacy for the resident but to stay in the immediate area. The resident also required extensive physical assistance to complete the task with one to two staff present.

PSW #110 was not available for interview during this inspection.

During an interview with Inspector #623, the DOC indicated that the expectation of the licensee is that care will be provided to the resident as specified in the plan. PSW #110 should not have left resident #009 and not return. The DOC indicated that the PSW should have also made an attempt to assist the resident #009 in accordance with the identified schedule, but did not.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #009 as specified in the plan. [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The licensee's policy Revera - Mandatory Reporting of Resident Abuse or Neglect #ADMIN-010-01 (effective August 31, 2016) indicated the following:

Procedure: Internal
- Where any person has reasonable grounds to suspect that any of the following has occurred or may occur, such person must immediately report the suspicion and the information upon which it is based to the person in charge (i.e. the nurse on duty). They will then together immediately report this to their legislative authority (Ontario - Director of the MOHLTC in accordance with the Critical Incident Reporting Requirements). Following this the nurse will document the suspicion in the chart of each resident involved.

The licensee’s policy Revera - Resident Non-Abuse #ADMIN1-020.02 (last reviewed March 31, 2019) indicated the following:

Procedure:

-the priority is to ensure the safety and comfort of the abuse victim(s) by taking steps to provide for their immediate safety and well-being, then complete full assessments.
-in cases of resident to resident abuse, staff shall ensure the residents are separated and tended to separately.
-in cases of physical abuse, staff are to ensure that accurate, detailed descriptions of injuries/condition are documented in the resident's charts
-the resident's SDM if any, will be notified immediately upon the home's knowledge of any alleged, suspected or witnessed incident of abuse.

Related to log #008417-18 for CIR

A Critical Incident Report (CIR) was submitted to the Director on an identified date but was called to the after hours reporting line on for an incident of alleged neglect that was reported to Registered Practical Nurse (RPN) #104 on an identified date. The Executive Director was made aware of the incident on a specified date and began an investigation. The CIR indicated that on a specified date resident #009 was discovered at a specified time in an identified room on a specified home area. The PSW staff began their shift at an identified time and were unaware how the resident was able to get in to the identified room, as it required a key that only staff would have.

During an interview with Inspector #623, RPN #104 indicated that they were working the identified shift when resident #009 was discovered in the locked room by the PSW. RPN #104 indicated that around a specified time, PSW #111 approached the RPN and indicated that resident #009 was not in their bed and asked if the resident was on a leave of absence (LOA). The RPN checked again and the resident was not signed out, so they began a search of the home area, which included looking behind every door. The RPN indicated that during the search, PSW #111 opened the locked door and discovered resident #009 standing in the room unaccompanied. RPN #104 indicated that they did not know how long the resident was in the room or how they got there, because it required a key to unlock the door. The staff on shift at the time did not let the resident in the identified room. RPN #104 indicated that the resident was not in distress and was unharmed. An assessment was completed by RPN #104, but it was not documented in the resident's clinical record at the time of the incident. RPN #104 indicated that they reported the incident to the next shift at report but did not contact the RN #116 who was the charge nurse on duty at the time of the incident. RPN #104 indicated that because they did not really know how long the resident was in the identified room, and when they discovered the resident they were not harmed, they did not feel this was reportable. RPN

#104 indicated at the time of the incident, resident #009 was ambulatory and could verbally express their needs to staff, but needed someone to direct them to the appropriate room. RPN #104 could not recall what assistance the resident required, if any to complete care. The RPN was also uncertain if the resident would be able to open the door to get out of the room unassisted, once the door was unlocked and they were let in. RPN #104 indicated that when abuse or neglect is suspected or witnessed, the expectation is that they would contact the RN in charge of the building to proceed with the reporting requirements.

During an interview with Inspector #623, the Director of Care (DOC) indicated that the incident was brought to their attention when a staff member approached management several days later indicating that the incident had taken place. Management began to look into the matter and after viewing the security video footage of the home area for that shift, it was discovered that the resident had been let into the room by PSW #110 at an identified time and the PSW did not return. It was not until the next shift came on and discovered the resident was not in their bed, when a thorough search of the home area was conducted, and the resident was discovered by PSW #111 to be in the locked room. The DOC indicated that RPN #104 oversaw the home area at the time the resident was missing and then discovered in the identified locked room. The staff that were working began their shift at a specified time and did not notice the resident missing for an identified period of time. The DOC indicated that the video footage indicated the resident was in the room for approximately four hours. The DOC indicated that the expectation of the licensee is that management would have been made aware of the discovery and a CIR initiated. The DOC indicated that this did not occur.

The licensee failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents was complied with when resident #009 was discovered to be unaccounted for on and was discovered on the home area, in a room that required a key to access approximately one and a half hours into the shift. RPN #104 failed to document the incident in the resident's records and failed to report the incident to the RN charge nurse on duty at the time.

2. Related to Log # 015679-19 - Critical Incident Report (CIR) Inspection #2019_815623_0014 and Complaint Inspection #2019_643111_0018 were inspected concurrently. Non-compliance was identified for complaint log #015679-19 and a similar non-compliance was identified in CIR Inspection #2019_815623_0014. A Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c.8, s.20(1) was identified in the inspection report 2019_643111_0018 dated September 4, 2019 which was inspected concurrently

with this inspection and will be reflected in this report.

A complaint was received by the Director on a specified date, alleging resident to resident abuse by resident #011 towards resident #003 and an unknown resident.

Review of the progress notes for resident #011 had no documented evidence of an alleged resident to resident abuse incident on the identified date.

Review of the progress notes of resident #003 indicated on a specified date, a late entry was completed for an incident that occurred one day prior, by RPN #102. The RPN indicated the resident's family reported that an unidentified resident was observed to display a specific responsive behaviour towards another unidentified resident and gesture to resident #003. The RPN informed the family that they would follow-up.

During an interview with RPN #102 by Inspector #111, they confirmed awareness of the allegation, confirmed the incident occurred on the identified date. The RPN indicated the family of resident #003, reported witnessing resident #011 exhibit specific responsive behaviours towards resident #012 and gesture at resident #003, which made resident #003 uncomfortable. The RPN confirmed they did not assess any of the residents involved, provided detailed descriptions of who was involved, did not document the incident until the following evening and did not report the incident to the nurse in charge (the RN), as per the home's abuse policy.

During an interview with the DOC by Inspector #111, they indicated no awareness of the allegation of resident to resident abuse between resident #003, #010 and resident #011. The DOC indicated RPN #102 who was notified of the allegation, should have immediately assessed all residents involved in the allegation and reported the allegation to the RN, should have documented the incident the day the allegation was received and notified all of the families of the allegation, as per their responsibilities in the home's abuse policy.

During a later interview with the DOC and ED by Inspector #111, they provided the Inspector the recording of the identified date and time on the unit where the three residents resided. This video recording demonstrated that at a specified time, resident#013 (and not resident #011) who was involved in the allegation of abuse towards resident #012 and resident #003. The video also indicated the allegation was determined to be unfounded.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, as there was an allegation of resident to resident abuse by the family of resident #003, the alleged residents involved in the allegation were not assessed, the incident was not documented until the following day and the RN charge nurse was not immediately informed. [s. 20. (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 by ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation was reported to the Director.

Related to log #008417-18 for CIR:

A CIR was submitted to the Director on a specified date but was called to the after hours reporting line on an identified date for an incident of alleged neglect that was reported to the Registered Nurse on a specified date. The Executive Director was made aware of the incident on an identified date and began an investigation. The CIR indicated that on a specified date resident #009 was discovered at a specified time in an identified room on a specific home area. The PSW staff began their shift at an identified time, and were unaware how the resident was able to get in to that identified room, as it required a key that only staff would have.

Review of the licensee's internal investigation by Inspector #623 identified that the CIR was not updated with the outcome of the investigation.

During an interview with Inspector #623, the Director of Care (DOC) indicated that the CIR for resident #009 was not updated following the conclusion of the licensee's internal investigation. The DOC indicated that the ED had completed the CIR.

During an interview with Inspector #623, the Executive Director (ED) indicated that following the licensee's investigation into the staff to resident neglect allegation CIR when resident #009 was left unattended in the identified room for approximately four hours, the ED indicated that the Director was not updated with the outcome of the investigation and that this was an oversight.

The licensee failed to ensure that the results of the alleged neglect investigation involving resident #009, were reported to the Director. [s. 23. (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 by ensuring that the results of the abuse of neglect investigation is reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to ensure that the homes written policy under section 29 of the Act, deals with; types of physical devices that are permitted to be used.

Related to log #008417-18 for CIR:

Inspector initiated inspection as a result of staff interviews and observations made during the CIR inspection. It was identified by staff and observed by Inspector #623 on an identified date, that resident #009 was currently using an identified device as a restraint.

Review of the licensee Revera’s policy #CARE10-010.01 LTC Least Restraint Program (effective date August 31, 2016, review date March 31, 2019) was completed by Inspector #623. The policy does not identify types of physical devices that are permitted to be used as a restraint.

During an interview with Inspector #623, the DOC indicated that the licensee's policy for the Least Restraint Program does not identify restraints that may be considered for use in the home. The DOC indicated that they were not aware that this information was missing from the policy. The DOC provided Inspector #623 with a copy of a draft policy for the Least Restraint Program which identifies restraints that may be considered for use in the home. This policy remains in the draft form and had not been implemented as of the time of the inspection.

The licensee has failed to ensure that the homes written policy for restraint use identifies types of physical devices that are permitted to be used. [s. 109. (d)]

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 by ensuring that the homes policy under section 29 of the Act, deals with types of physical devices that are permitted to be used, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class specifically poesy mitts for resident #009.

Related to log #008417-18 for CIR:

Inspector initiated inspection as a result of staff interviews and observations made during the CIR inspection. It was identified that resident #009 was currently using a specific identified restraint. Review of the clinical records for resident #009 indicated the following:

The restraint consent form was signed by the Substitute Decision Maker (SDM) and dated on an identified date. The consent form stated the restraint the was being consented to was identified due to specific responsive behaviours.

Review of the physician orders indicated that a telephone order was received by RPN #100 on a specified date that stated: an identified restraint as per family's request.

Review of the progress notes for a specific identified period of time indicated the specific identified restraint was documented as applied on two occasions prior to staff obtaining an order for the restraint.

During an interview with Inspector #623, RN #114 indicated that they could not be certain of when resident #009 began to actually use the identified restraint. The RN indicated that an order was not received until a specified date and the consent was received from the SDM approximately three weeks prior to the order being obtained. RN #114 indicated that they believed there was a trial period for the restraint to see if it would be effective.

During an interview with Inspector #623, RPN #100 indicated that they obtained a physicians order over the telephone on an identified date for the use of the restraint, after the device was trialled and found to be beneficial.

The licensee failed to ensure that the physical restraint device for resident #009 was ordered and approved by a physician or registered nurse in the extended class, before it was applied. [s. 110. (2) 1.]

2. The licensee has failed to ensure that staff apply the physical device in accordance with instructions specified by the physician or registered nurse in the extended class.

Related to log #008417-18 for CIR:

Inspector initiated inspection as a result of staff interviews and observations made during the CIR inspection. It was identified that resident #009 was currently using a specific identified restraint. Review of the clinical records for resident #009 indicated the following:

A Physician order for resident #009 that was written on a specified date as a telephone order received by RPN #100 indicating: The specified restraint as per family's request. The order does not specify instructions for when the restraint was to be applied or removed.

During separate interviews with Inspector #623, PSW #112 and PSW #113 indicated that

they provide care to resident #009 on an identified shift. It was indicated by both PSW's that a recent intervention was put into place to prevent the resident from grabbing at staff and from exhibiting a specific behaviour. The resident now has a restraint that is put into place on the evening shift and to remain in place overnight.

During an interview with Inspector #623, RN #114 indicated that the identified restraint for resident #009 are to be used any time care is being provided and once the resident is placed into bed for the night. The RN indicated that at night the restraint is to be in place at all times. RN #114 indicated that the restraint is also used during the day when care is provided to prevent the resident from exhibiting responsive behaviours during care.

During an interview with Inspector #623, RPN #100 indicated that they obtained the physician order on an identified date by telephone. RPN #100 indicated that they were unaware that the order needed to indicate specific instructions for use, so the order only indicated that the restraint could be used as per family request.

The licensee has failed to ensure that staff apply the physical device in accordance with instructions specified by the physician or registered nurse in the extended class for resident #009 when the physician's order that was written did not indicate any instructions for the use of the identified restraint. [s. 110. (2) 2.]

3. The licensee failed to ensure that the resident is monitored at least every hour while restrained by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.

Related to log #008417-18 for CIR:

Review of the clinical records for resident #009 indicated the following:

The progress notes identified on a specific date and time RN #126 documented that the identified restraint was supplied by the ADOC and were applied to resident #009. On a specified date and time RN #127 documented that the identified restraint had been in place since coming on duty and were removed for assessment of the resident. On a specified date BSO RPN #100 documented that a note was placed above resident #009’s bed to indicated that the identified restraint was to be applied on the evening and night shift and to be removed on days.

Review of the Point of Care (POC) documentation record for a specified period of time

indicated that there was no documentation to support hourly monitoring of resident #009 took place while the identified restraint was in place. Documentation was completed by the PSW staff one time on the evening and one time on the night shift indicating that the restraint was in use and still required.

During an interview with Inspector #623, PSW #112 and PSW #113 indicated that they provide care for resident #009. Both PSW’s indicated that a recent intervention was put into place to prevent resident #009 from grabbing at staff and from exhibiting specific responsive behaviours. The resident now requires a restraint to be put into place by the evening shift and remain in place overnight. The PSW’s indicated that the identified device is considered a restraint. PSW #112 indicated that restraints must be documented on hourly when applied and released every two hours. This documentation is completed in the POC charting.

During an interview with Inspector #623, the DOC indicated that resident #009 does have an identified restraint on the evening and nights. The DOC indicated that after reviewing the clinical records for resident #009 it was identified that the specific restraint began to be in use on an identified date and there is no record of restraint documentation hourly since the implementation of the restraint. The DOC indicated that the expectation of the licensee is that the resident is monitored at least every hour while restrained and that the monitoring is documented. The DOC indicated that the restraint policy is to be followed.

The licensee failed to ensure that resident #009 was monitored at least every hour while restrained, by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff. [s. 110. (2) 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 by ensuring that staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class. By ensuring that staff apply the physical device in accordance with instructions specified by the physician or registered nurse, and by ensuring that the resident is monitored at least every hour while restrained by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff, to be implemented voluntarily.

Issued on this 4th day of October, 2019

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

Original report signed by the inspector.