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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 24, 2018	2018_555506_0013	006037-18	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Waterford Long Term Care Residence
2140 Baronwood Drive OAKVILLE ON L6M 4V6

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

LESLEY EDWARDS (506), DIANNE BARSEVICH (581)

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): March 28, 29, April 4, 5, 6, 10, 11, 12 and 13, 2018.

During this inspection the following inspections listed below were conducted concurrently:

Complaints

000018-18 - related to staffing
002156-18 - related to staffing concerns, availability of supplies and personal support services
002824-18 - related to abuse and neglect
002834-18 - related to abuse and neglect, staffing and medications
003934-18 - related to staffing, availability of supplies, transferring and positioning

Critical Incidents

011462-17 - related to resident to resident abuse and neglect
023613-17 - related to staff to resident abuse and neglect
023815-17 - related to abuse and neglect
028510-17 - related to abuse and neglect
029072-17 - related to falls prevention
000789-18 - related to resident to resident physical abuse
002244-18 - related to resident to resident physical abuse
000850-18 - related to staff to resident abuse and neglect

During the course of the inspection, the inspector(s) spoke with Administrator, Directors of Care (DOCs), Resident Assessment Instrument (RAI) Coordinator, Assistant Director of Care (ADOC), Physiotherapist Assistants (PTAs), Registered Dietitian (RD), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), Programs Support Services Manager, Behavioural Support Ontario staff (BSO), residents and residents' family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed medication passes, reviewed clinical records, policies and procedures, the home's complaints process, staffing schedules, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **9 WN(s)**
- **6 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for residents provides clear directions to staff and others who provide direct care to the resident.

In an interview with resident #022 on an identified date in April 2018, they confirmed they received an intervention two times per week. A review of the clinical record confirmed that the resident prefers to have a specific intervention twice a week under an area in the care plan and in another area of the plan it indicated that the resident was to have both types of intervention twice per week. An interview with DOC #106 on an identified date in April 2018, they confirmed that the resident's plan of care does not provide clear

to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

i. Review of the plan of care for resident #032 identified they fell and sustained an injury on an identified date in December 2017. They also fell on two other dates and sustained injuries. Review of the Minimum Data Set (MDS) assessment on an identified date in December 2017, indicated they had a significant change in their status and they had a fall in the last 30 days but did not identify they had a fall in the past 31-180 days. Interview and review of the clinical health record with RN #111 they stated the resident had falls within the past six months and confirmed that the MDS assessments and the post falls analysis assessments were not integrated, consistent with and complemented each other.
ii. Review of the Resident Assessment Profile (RAP) for resident #006 on an identified date in June 2017 and a progress note, identified the intervention was removed. Review of the Bladder Continence Assessment completed on an identified date in August 2017, identified that the resident had the intervention in place. Interview and review of the clinical record with RN #118 stated the resident had a an intervention but was removed in June 2017 and confirmed that the RAP assessment and the Bladder Continence Assessment were not integrated and consistent with each other.
iii. Review of the RAP on an identified date in March 2018, for resident #007 identified they used an intervention. Review of the resident's continence logo and the Resident Profile Worksheet identified they used a specific intervention on all three shifts. Interview with PSW #101 stated the resident uses the intervention every shift and verified that the logo and the worksheet were not accurate. Interview with RN #120 and review of the plan of care confirmed the resident used the intervention and confirmed that the RAP assessment and the logo's and worksheet were not integrated and consistent with each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in their plan.

i. On an identified date in December 2017, resident #022 reported to DOC #106 that PSW #119 did not not complete an intervention for several hours on an identified date in December 2017. The DOC completed their internal investigation and it was verified that the resident did not receive care as specified as written in their plan of care. (506)

ii. On an identified date in September 2017, resident #045's had a specified treatment. Clinical record review and interview with RPN #124 confirmed on an identified date in September 2017, they did not follow the resident's plan of care as this intervention was not tried. DOC #106 on an identified date in 2018, confirmed the staff member did not follow the resident's plan of care. (506)
iii. Review of resident #006's logo and the Resident Profile Worksheet last updated in 2018, identified they were assessed to use one type of intervention and another intervention throughout the day. On an identified date in March 2018, the resident was not using the required intervention. Interview with PSW #104 stated they provided care to the resident and they did not follow the logo or the worksheet. Interview with RPN #103 stated that PSW staff were to follow the logos and the worksheet and confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. (581)
iv. On an identified date in January 2018, resident #046 sustained an injury to an area when PSW #134 completed an intervention with the resident by them self. Review of the written plan of care indicated that the resident intervention was to be completed with two staff. Interview with PSW #134 verified that they completed the intervention with one staff. Interview with RN #106 stated the care was not provided as specified in the plan. (581) [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

On an identified date in April 2018, resident #032 was observed seated and there was no intervention in place. On an identified date in October 2017, an intervention was put in place. Interview with PSW #112 stated the resident does not use the intervention and was not aware that they ever had one. Interview with RN #113 stated the resident did not have the intervention. Interview with DOC #106 who revised the written plan of care to include the intervention, confirmed that the resident refused to have the intervention and registered staff removed the intervention but did not revise the plan of care when the care needs changed. [s. 6. (10) (b)]

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 staff and others collaborate with each other in the assessments of the residents so that their assessments are integrated, consistent with and compliment each other. To ensure that the care set out in the plan of care is provided to the residents as specified in their plan and to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents care needs changed or care set out in the plan are no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the home's policy, Resident Falls, policy no: LTC-CA-WQ-200-07-08, revised date December 2017, directed staff post fall to document in the progress notes using the Occurrence Note and if the fall was the first one in a quarter registered staff were to complete a Post Fall Analysis in point click care.
On an identified date in January 2018, resident #035 fell and sustained an injury. Review of the clinical record identified they were at risk of falling and that a post falls assessment (occurrence note) and the post fall analysis were not completed post fall. This was confirmed by RN #106 during an interview. [s.49. (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 a resident has fallen, the resident was assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours.

Review of the clinical record identified that resident #034 demonstrated responsive behaviours including but not limited to verbal and physical aggression. Review of the progress notes in March 2018, indicated that the resident was seen by an outside service and suggested that specific interventions be used when the resident was in common areas. On an identified date in April 2018, the written plan of care identified that staff were to use the specified interventions to help prevent responsive behaviours. Resident #034 was observed through out the course of the inspection seated in common areas without the use of the specified intervention. Interview with BSO staff #136 and #137 verified they provided the specified intervention on the unit but the intervention was not being used for the resident currently. They both confirmed this specific strategy and intervention was not implemented to assist with managing the resident's responsive behaviours. [s. 53. (4) (b)]

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 residents demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours., to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that restraining of a resident by a physical device under section 31 or 36 of the Act, was applied by staff in accordance with any manufacturer's instructions.

i. On an identified date in April 2018, resident #031 was observed with an intervention that was not applied correctly. Review of the manufacturer's instructions for the intervention identified that the when the intervention would fit snug so that it was secure. Review of the plan of care identified they required the intervention which was applied for safety and was to be applied according to manufacturer's instructions. Interview with RPN #103 confirmed the intervention was applied incorrectly and that it should have been applied according to manufacturer's instructions.
ii. On an identified date in April 2018, resident #036 was with an intervention that was not applied correctly. Review of the manufacturer's instructions for the intervention identified that the intervention should be applied securely with no slack. Review of the clinical record identified they required the intervention for safety and was to be applied according to manufacturer's instructions. Interview with RN #129 and RPN #127 both stated that the resident required intervention and that it should have been applied according to manufacturer's instructions. [s. 110. (1) 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 restraining of a resident by a physical device under section 31 or 36 of the Act, was applied by staff in accordance with any manufacturer's instructions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

i. Resident #012 had a physician's order for medication to be applied daily. On an identified date in October 2017, the RN noted that the resident had the wrong dose of the medication applied. Upon further investigation it was noted that the box provided from the pharmacy which contained 30 doses were labelled with a different dose than the medication inside the box. The resident was applied the wrong dose of the medication for three days. DOC #105 confirmed on an identified date in April 2018, that the medication was not administered to the resident in accordance with the directions for use specified by the prescriber.
ii. Resident #016 had regularly scheduled medications that were to be given at specified times. On an identified date in November 2017, it was noted that the resident did not receive these medications as directed. DOC #105 confirmed on an identified date in April 2018, that the following medications were not administered to the resident in accordance with the directions for use specified by the prescriber.
iii. Resident #015 had a physician's order for a medication at a specified time. On an identified date in November 2017, it was noted that the resident received the medication at the wrong time. DOC #105 confirmed on an identified date in April 2018, that the medication was not administered to the resident in accordance with the directions for use specified by the prescriber.
iv. Resident #045 had an order for a medication to be administered a specific way . On an identified date in 2017, RPN #124 confirmed that the resident's specified intervention was not functioning and they had to administer the medications to the resident through a different method. RPN #124 confirmed on an identified date in April 2018, that the resident did not get the required dose of the medication required and the medication was not administered to the resident in accordance with the directions as specified by the prescriber. [s. 131. (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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed, (b) corrective action was taken as necessary, and (c) a written record was kept of everything required under clauses (a) and (b).

According to progress notes resident #045 had an order for a specific medication. On an identified date in September, 2017, RPN #125 confirmed that the resident's specified intervention was not functioning and they had to administer the medications to the resident through a different method during the shift and confirmed that the resident did not receive the required dose of the medication. In an interview with DOC #106 on an identified date in April 2018, confirmed the registered staff had not documented the incident using the home's medication incident report. The incident was also not documented or discussed at the home's Professional Advisory Committee, therefore the incident was not reviewed or analyzed, and corrective action had not been taken to prevent this type of incident from occurring again in the home. This was confirmed by DOC #106. [s. 135. (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 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), to be implemented voluntarily.

WN #7: 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 failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s.20 (2) d, the duty under section 24 to make mandatory reports.

The home's policy that was in place at the time of an incident of alleged abuse. [Abuse Allegations and Follow-up, LTC-CA-WQ-100-0502, last revised July 2016], directed staff to immediately report the suspicion of any witnessed or alleged abuse immediately to the person who is in charge of the building and that they are obligated by legislation to report the incident Ministry of Health Long Term Care (MOHLTC) Director.
i. A Critical Incident System report was submitted to the Director on an identified date in June 2017, reporting an allegation of abuse that took place on an identified date in June 2017. A review of the home's investigative notes identified that the family of resident #019 reported the incident to RPN #113 and PSW #116 on an identified date in June 2017. When RPN #113 returned to work the next day they saw that there was no report or documentation regarding the allegation of abuse to resident #019 and then initiated the home's policy regarding abuse allegations. In an interview with the DOC #106 on an identified date in April 2018, confirmed that the staff did not follow the home's abuse policy and immediately report the alleged abuse to the MOHLTC Director or to the person in charge at the time. [s. 20. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director.

A Critical Incident System report was submitted to the Director on an identified date in June 2017, reporting an allegation of abuse that took place on an identified date in June 2017. A review of the home's investigative notes identified that RPN #113 and PSW #116 were made aware of the allegation of abuse on an identified date in June 2017. In an interview with DOC #106 on an identified date in April 2018, confirmed that the staff did not immediately report the allegation of abuse to the MOHLTC Director. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian (RD) who was a member of the staff of the home, and that any changes made to the plan of care related to nutrition and hydration were implemented.

On an identified date in January 2018, resident #035 sustained an area of altered skin integrity. A review of the clinical record identified there was no record of a referral to the RD or any assessments completed by the RD as a result of the altered skin integrity. Interview with the RD on an identified date in April 2018, stated they were to receive a referral from registered staff for all altered skin integrity and confirmed they did not receive a referral and did not complete an assessment of the resident's altered skin integrity. [s. 50. (2) (b) (iii)]

Issued on this 25th day of April, 2018

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

Original report signed by the inspector.