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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2014	2014_235507_0020	T-019-14	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

CUMMER LODGE
205 CUMMER AVENUE NORTH YORK ON M2M 2E8

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

STELLA NG (507), JOELLE TAILLEFER (211), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 3, 4, 5, 6, 7, 10, 12, 13, 14 and 17, 2014.

The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T-754-14, T-1160-14, T-1202-14 and T-1340-14.
The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T-250-14, T-331-14, T-905-14, T-1057-14 and T-1140-14.

During the course of the inspection, the inspector(s) spoke with administrator, assistant administrator, director of care (DOC), nurse managers (NMs), registered staff, personal care aides (PCAs), medical director, home physician, registered dietitian (RD), nutrition manager, food service worker (FSW), RAI coordinator, manager of building services (MBS), councilor, residents, family members of residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

8 WN(s)
4 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Record review of an identified resident's written plan of care indicated that the resident requires a one-person physical assist for toileting during the day. Interviews with personal care aides (PCAs) and the identified registered staff confirmed that the resident does not want to be assisted by staff for toileting, and he/she manages toileting by

him/herself safely.

Record review revealed and interview with the identified registered staff confirmed that the resident's refusal to be assisted for toileting is not reflected in the written plan of care.

Record review of a second identified resident's written plan of care indicated that the resident requires a one-person physical assist for toileting during the day. Interviews with the PCAs and the identified registered staff confirmed that the resident does not want to be assisted by staff for toileting, and he/she manages toileting by him/herself safely.

Interview with the identified registered staff confirmed that the resident's refusal to be assisted for toileting is not reflected in the written plan of care. [s. 6. (1) (c)]

2. Record review of the written plan of care for an identified resident indicated that the resident is unable to reposition him/herself while sitting in a chair and staff are to reposition the resident. The written plan of care stated that the frequency for repositioning the resident while he/she sitting in a chair is hourly in one section and every two hours in another.

Interview with an identified PCA confirmed that he/she repositions the resident every two hours and the plan of care is unclear about how frequently staff are to reposition the resident while in a chair. Interview with the identified registered staff confirmed that the written plan of care does not set out clear directions in relation to the frequency of repositioning the resident while in a chair.

Record review of the written plan of care for a second identified resident indicated that the resident is unable to reposition him/herself while sitting in a chair and staff are to reposition the resident. The written plan of care stated that the frequency for repositioning the resident while he/she is sitting in a chair is hourly in one section and every two hours in another.

Interview with an identified PCA confirmed that he/she repositions the resident every two hours and the plan of care is unclear about how frequently staff are to reposition the resident while he/she is sitting in a chair. Interview with the identified registered staff confirmed that the written plan of care does not set out clear directions in relation to the frequency of repositioning the resident while in a chair. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care is based on

an assessment of the resident and the needs and preferences of that resident.

On an identified date, the inspector observed that an identified resident was sitting in a chair and the chair was tilted to an angle. Record review revealed that the written plan of care does not indicate the chair should be tilted.

Interview with the identified registered staff and the identified PCA confirmed that the resident is unable to reposition while in a chair. When the resident is in a chair, the chair should be tilted for proper positioning. The above mentioned staff members confirmed that the written plan of care is not based on the resident's needs for proper positioning while he/she is sitting in a chair. [s. 6. (2)]

4. On the same day, the inspector observed that a second identified resident was sitting in a chair and the chair was tilted to an angle. Record review revealed that the written plan of care does not indicate the chair should be tilted.

Interview with the identified registered staff and the identified PCA confirmed that the resident is unable to reposition while he/she is sitting in a chair. When the resident is sitting in a chair, the chair should be tilted for proper positioning. The above mentioned staff members confirmed that the written plan of care is not based on the resident's needs for proper positioning while he/she is sitting in a chair. [s. 6. (2)]

5. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Record review of the Minimum Data Set (MDS) assessment on four identified dates in a period of 10 months revealed that an identified resident has impaired vision. Record review of the annual health examination completed by the medical doctor on an identified date during that period indicated that resident has normal vision.

On an identified date, the inspector observed that identified resident was reading a newspaper outside the nursing station without wearing glasses or using any assistive devices for reading. Interviews with the identified registered staff and the identified PCA confirmed that the resident has adequate vision and does not wear glasses.

Interviews with the identified registered staff confirmed that there is no significant change

in the resident's health status related to his/her vision since the above mentioned annual health examination conducted. The staff confirmed that the above mentioned MDS assessments for the resident's vision are incorrect. The MDS assessments and the annual health examination are inconsistent and they do not complement each other in relation to the resident's visual function. Staff did not collaborate to ensure that the assessments are consistent. [s. 6. (4) (a)]

6. Record review revealed that an identified resident exhibits responsive behaviours and the resident was placed on hourly monitoring for a period of three weeks. Record review and interviews with an identified registered staff and an identified nurse manager (NM) confirmed that the hourly monitoring of the resident was discontinued because the resident did not exhibit any responsive behaviours documented on the Modified Dementia Observational System (DOS) during the observation period.

Record review of the nursing and personal care record for the period that the resident was placed on hourly monitoring indicated that the resident exhibited responsive behaviours on five days. Interview with an identified PCA revealed that when the resident exhibited responsive behaviours, the staff document in the nursing and personal care record.

Record review of the progress note and interview with the identified registered staff confirmed that the resident demonstrated responsive behaviours on the first day that the DOS was discontinued. The identified registered staff and the NM confirmed that the decision to discontinue the DOS was made without referencing to the personal care record. [s. 6. (4) (a)]

7. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, 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.

Record review of the MDS on an identified date indicated that an identified resident has responsive behaviours, and this piece of information is not included in the resident's written plan of care.

Interview with the Resident Assessment Instrument (RAI) coordinator revealed that different staff were completing the MDS and the written plan of care, and he/she was aware that staff members did not collaborate with each other in the assessment of the

residents and the development of the written plan of care.

Interviews with an identified registered nurse and the nurse manager confirmed that the identification of the resident's responsive behaviours and the specific strategies to control the behaviour were not incorporated in the resident's written plan of care. [s. 6. (4) (b)]

8. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

Record review revealed that an identified resident had an open area with foul drainage from one of the limbs on an identified date. A stage II pressure ulcer on the limb was documented nine days later. Three months later, a small skin breakdown on the resident's body was observed; and it was documented as a stage II pressure ulcer five days later. Both pressure ulcers were not healed three months after the open area on the limb was observed.

Review of the resident's written plan of care indicated that the resident is totally dependent on two staff to turn from side to side, reposition and transfer. Interventions for the healing of pressure ulcers include repositioning the resident every one to two hours when in bed and chair, applying dressing to both ulcers daily.

Interview with the identified NM confirmed that the assigned PCA or the registered staff is responsible for initialing on the "change positioning form" after repositioning the resident at specific times.

Record review and interviews with the identified NM and the identified registered staff confirmed that the repositioning every one to two hours for the identified resident was not documented at all. In addition, the dressing to one of the pressure ulcers were not documented on five days during the period. [s. 6. (9) 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:
1. there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
2. the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident,
3. the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other,
4. the staff and other involved in the care of the resident collaborate with each other 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, and
5. the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Regulation section 50(2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian (RD) 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.

The home's policy titled "Skin Care and Wound Prevention and Management", policy #RC-0518-02, revised October 1, 2010 indicates that residents who have stage II pressure ulcers are to be referred to the registered dietitian, for nutritional assessment and diet/ supplementation orders. This policy is not in accordance with the regulation that states the RD is to make an assessment of any resident with "altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds" and does not refer to any specific staging of skin breakdown.

Interview with the director of care (DOC) confirmed that the home is in the process of revising the Skin Care and Wound Prevention and Management policy. [s. 8. (1) (a),s. 8. (1) (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 the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is kept clean and sanitary.

During the course of the inspection, the inspector observed the following:
- On an identified unit, the soap dispenser in the shower cubicle was covered with a dirty white film in the shower room, and the toilet bowls were dirty in the shower rooms, and
- On another two identified units on an identified floor, the soap dispensers in all shower cubicles were covered with a dirty white film, the toilet bowls were dirty, the bath tubs in two shower rooms were dusty, and the floor of all the shower rooms was dirty.

Interview with the manager of the building services (MBS) confirmed that the above mentioned areas were not kept clean. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home is maintained in a good state of repair.

On an identified date, the inspectors observed the following:
- dents and chipped paint on walls and doors in two identified residents' rooms,
- scratch marks on closet and walls in a third identified resident's room and bathroom, and
- scratch marks on handrails along the hallway of rooms S304 - S319.

Interview with the MBS confirmed that painting is required for the above mentioned areas. [s. 15. (2) (c)]

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 the home is kept clean and sanitary, and is maintained in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive skin and wound care training, as a condition of continuing to have contact with residents.

Record review and interview with the assistant administrator confirmed that 29.2 per cent of staff who provide direct care to residents did not receive training in skin and wound care in 2013. [s. 221. (1) 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 all staff who provide direct care to residents receive skin and wound care training, as a condition of continuing to have contact with residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways are,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

On an identified date, the inspector observed that on an identified floor resident home area, the door leading to stairway #2 was closed but not locked. In addition, the door was not equipped with a door access control system and an audible door alarm that allows calls to be cancelled only at the point of activation.

Interview with the BMS confirmed the above mentioned observation. [s. 9. (1) 1.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

On an identified date, the inspectors observed the following call bells not functioning, and staff were notified:
- call bell in an identified resident's room, and
- call bells in two other identified residents' bathrooms.

On the next day, the inspector observed the above mentioned call bells functioning. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

Over the course of the inspection, the inspector observed that the following common resident home areas were not equipped with a resident-staff communication and response system:
- South side of the third floor: Rooms #S335, #S336 and TV lounge,
- North side of the third floor: Room #N337,
- South side of the fourth floor: Rooms #S437, #S436 and #S453, and
- North side of the fourth floor: Rooms #N440, #N437 and the small family room across from the resident room #N451.

Interview with the BSM confirmed that residents have access to the above mentioned areas and there is no resident-staff communication and response system available in these areas. [s. 17. (1) (e)]

WN #7: 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 has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Record review revealed that a small skin breakdown was observed on an identified resident's body on an identified date. A stage II pressure ulcer was documented five days later. Intervention of dressing daily was not initiated until seven days after the skin breakdown was observed.

Interview with the identified nurse manager confirmed that immediate intervention was not provided to the resident to promote pressure ulcer healing. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

Record review revealed that an identified resident had an open area with foul drainage from one of the limbs on an identified date. A stage II pressure ulcer on the limb was documented nine days later. Three months later, a small skin breakdown on the resident's body was observed; and it was documented as a stage II pressure ulcer five days later. Both pressure ulcers were not healed three months after the open area on the limb was observed.

Record review revealed and interviews with the RD and the identified NM confirmed that the resident was not referred to the RD for assessment until three months after after an open area on the resident's limb was observed. [s. 50. (2) (b) (iii)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On an identified date, during lunch meal service in an identified dining room, the inspector observed an identified PCA serving an identified resident lunch. The resident's family member arrived when the PCA was about to assist the resident with lunch, and the family member took over the assisting with meals. The family member took the soup from the table and brought to the attention of the food service worker (FSW) that the resident is allergic to the ingredient in the soup, and he/she cannot have the soup.

Interview with the PCA who served the soup to the resident confirmed that he/she asked the FSW for the meal for the resident, and he/she did not check the diet information sheet. Interview with an identified nutrition manager revealed that he/she was approached by the identified PCA for a cup of soup, and did not identify the resident's name. The nutrition manager confirmed that he/she should check the diet information sheet prior to serve meals. However, he/she did not ask for the resident's name, nor refer to the diet information sheet.

Review of the home's policy titled, "Dining Room – Point of Service Tools", policy # RC-0523-06 states that staff to serve meals using the information documented on the Diet Information Sheets. Review of the diet information sheet for the identified unit listed on the day of observation, indicates that the identified resident is allergic to the ingredient in the soup for the day. [s. 73. (1) 5.]

Issued on this 3rd day of December, 2014

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

Original report signed by the inspector.