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

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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
Feb 8, 2016	2016_248214_0002	035438-15	Resident Quality Inspection

Licensee/Titulaire de permis

SHALOM MANOR LONG TERM CARE HOME
12 Bartlett Avenue GRIMSBY ON L3M 4N5

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

SHALOM MANOR LONG TERM CARE HOME
12 BARTLETT AVENUE GRIMSBY ON L3M 4N5

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

CATHY FEDIASH (214), GILLIAN TRACEY (130), KELLY HAYES (583)

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): January 12, 13, 14, 15, 18, 19, 20, 21, 25, 2016.

Please note: The following inspections were conducted simultaneously with this RQI:
-Complaint inspection 020064-15 related to visitation and finances.
-Critical Incident System inspection 009127-14 related to a fall and responsive behaviours.
-Critical Incident System inspection 001715-15 related to medication administration.
-Critical Incident System inspection 010931-15 related to a fall.
-Critical Incident System inspection 012474-15 related to a fall.
-Critical Incident System inspection 018702-15 related to burns.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Director of Resident Care (DRC), Associate Director of Resident Care (ADRC), Manager of Recreation & Environmental Services, Resident Assessment Instrument (RAI) Coordinator, registered staff, Personal Support Workers (PSW), President of Residents' Council, family representative of the Family Council, resident's and families. During the course of this inspection, the inspector's toured the home; reviewed resident health records; reviewed meeting minutes and internal investigation records; reviewed policies and procedures; observed resident's in dining and care areas.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

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

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

Specifically failed to comply with the following:

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

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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident and the goals the care was intended to achieve.

According to the clinical record reviewed for a period of eight months in 2015, resident #009 had identified alterations in their skin integrity to various parts of their body. A written plan of care was not developed to identify the ongoing skin alterations and potential risk factors related to their skin alterations until several months later on an identified date in 2015.

The DRC confirmed the written plan only identified one area of skin alteration and did not identify the other affected areas. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A review of resident #006's current written plan of care and kardex indicated that the resident had a specialized treatment in place. A review of the resident's Original Physician's Orders and Electronic Treatment Administration Record (eTAR) for identified time periods in 2015 and 2016, indicated two different specialized treatments in place. An interview with the DRC confirmed that the written plan of care for the resident did not set out clear directions to staff and others who provided this specialized treatment to the resident. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of resident #006's Minimum Data Set (MDS) coding for the quarterly review assessment's dated on identified dates in 2015, indicated under section G.-Physical Functioning and Structural Problems that the resident was coded as being bedfast all or most of the time. A review of the corresponding narrative Resident Assessment Protocol (RAP) indicated that the resident was up almost every day for one to two hours. A review of the resident's plan of care in place during this identified period of time indicated that the plan did not identify the resident's needs and preferences to be bedfast. An interview with the RAI Coordinator confirmed that the resident was receiving bedfast care to promote the healing of altered skin integrity to an identified area. An interview with the RAI Coordinator and the DRC confirmed that the resident's plan of care was not based on an assessment of the resident's needs and preferences. [s. 6. (2)]

4. 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 complemented each other.

On an identified date in 2015, the quarterly MDS coding indicated that resident #009 had five identified areas of skin alteration. The RAP completed during the same time period indicated the one area of altered skin integrity; however; there was no mention of the other four areas of altered skin integrity. Progress notes during the same time period indicated the resident had multiple skin alterations to different identified areas. The DRC confirmed that due to the resident's diagnosis, they had recurring skin alterations requiring treatment.

The DRC confirmed that staff did not collaborate in the assessment of the resident's altered skin integrity. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident and the goals the care is intended to achieve, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date in 2015, resident #100 sustained an injury to an identified area of their body during a transfer technique. According to staff #160, while staff #238 was completing the transfer technique, equipment came into contact with a heat-lamp bulb and broke.

On an identified date in 2015, staff did not use safe transferring technique when transferring resident #100.

This non compliance was identified as a result of Critical Inspection #018702-15, which was conducted simultaneously with the RQI. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the falls prevention and management program to reduce the incidences of falls and the risks of injuries was fully implemented.

In an interview with the ADRC and DRC on an identified date in 2016, it was confirmed that the home had not yet implemented a clinically appropriate assessment instrument that was specifically designed for assessment of falls or formed their interdisciplinary falls prevention committee. [s. 48. (1) 1.]

2. The licensee failed to ensure that the continence care and bowel management program that promotes continence, and ensures that residents were clean, dry and comfortable was fully developed and implemented.

The Administrator confirmed that the home had not yet implemented a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 48. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the falls prevention and continence care and bowel management programs are fully developed and implemented, to be implemented voluntarily.

WN #4: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff within 24 hours of the resident's admission.

A review of resident #006's clinical record indicated that they were admitted to the home on an identified date in 2015, with altered skin integrity to an identified area on their body. A review of the resident's clinical records indicated that the resident did not receive a skin assessment by a member of the registered staff until 15 days later. An interview with the DRC confirmed that a skin assessment was not completed within 24 hours of the resident's admission. [s. 50. (2) (a) (i)]

2. The licensee failed to ensure that a resident at risk of altered skin integrity received a

skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A review of resident #006's clinical records indicated they were admitted to hospital for an identified period of time in 2015. The clinical records indicated that the resident had altered skin integrity to an identified area on their body that was present at the time of admission to hospital and upon discharge back to the home. A review of the resident's clinical records indicated that the resident did not receive a skin assessment by a member of the registered staff upon their return from hospital. An interview with the DRC confirmed that a skin assessment was not completed for this resident upon their return from hospital. [s. 50. (2) (a) (ii)]

3. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an identified date in 2015, resident #100 sustained an injury resulting in alteration to their skin integrity. The DRC confirmed staff did not assess the resident's skin using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, after sustaining the injury.

This non compliance was identified as a result of Critical Incident Inspection #018702-15, which was conducted simultaneously with the RQI. [s. 50. (2) (b) (i)]

4. The licensee failed to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of resident #006's clinical record indicated that they exhibited an alteration in skin integrity to an identified area on their body that was present on their admission in 2015. A review of the resident's clinical record including progress notes and assessments in Point Click Care (PCC) was conducted for a period of 12 weeks during identified dates in 2015 and 2016. This review indicated that weekly re-assessments of the resident's wound were not completed on four identified dates in 2015. An interview with the DRC confirmed that the resident was not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff within 24 hours of the resident's admission and upon any return of the resident from hospital; to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 and that the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, 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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of a Critical Incident System (CIS) submitted by the home indicated that on an identified date in 2015, resident #200 was transferred to hospital after receiving medications that were prescribed for another resident. A review of the resident's clinical record indicated that the resident had an allergy to one of the medications they had received. An interview with the DRC confirmed that the home had not ensured that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

This non compliance was identified as a result of Critical Incident Inspection #001715-15, which was conducted simultaneously with the RQI. [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 are 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. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

During a family interview with resident #002's family member on an identified date in 2016, it was shared they did not recall being invited to a care conference and to their knowledge a care conference had not taken place. The electronic and paper plan of care was reviewed for an identified period of nine months from resident #002's date of admission and it was identified that there was no documented record of the care conference. An interview with the DRC on an identified date in 2016, confirmed that a care conference of the interdisciplinary team was not held within six weeks of resident #002's admission. [s. 27. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the home's annual program evaluation for the Skin and Wound Care Program 2015 indicated the date of the evaluation and the names of the persons who participated in the evaluation; however; had not included a summary of the changes made and the date that any changes were implemented. An interview with the DRC confirmed that the home had made changes to their Skin and Wound Care Program and that the annual program evaluation had not included all of the required information. [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

On an identified date in 2014, resident #102 was involved in an incident with resident #101, which resulted in injury to resident #101. The DRC confirmed that there was no documentation recorded in resident #102's chart to indicate actions that were taken at the time of the incident. [s. 30. (2)]

WN #8: 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 circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #500's falls risk assessment completed on an identified date in 2015, indicated they were at high risk for falls. A review of the plan of care identified resident #500 had an unwitnessed fall on an identified date in 2015. The resident sustained injuries to identified areas on their body and was transferred to hospital. A diagnostic test completed on an identified date in 2015, indicated that resident #500 sustained an injury to an identified area on their body. A review of the clinical record identified that there was no documented post-fall assessment following this fall.

In an interview with the ADRC and the DRC on an identified date in 2016, it was confirmed that a post falls assessment was not completed for resident #500 after their fall with injury using a clinical appropriate tool specifically designed for falls. It was shared that the post fall assessment tool had not yet been implemented in PCC.

This non compliance was identified as a result of Critical Incident Inspection #012474-15, which was conducted simultaneously with the RQI. [s. 49. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and ensured it was conducted using a clinically appropriate assessment instrument specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) A review of resident #007's plan of care identified their bladder continence was assessed to have worsened. The MDS bladder continence assessment completed on an identified date in 2015, was coded as one, usually continent and the MDS assessment completed on the following quarterly assessment review was coded as two, occasionally incontinent. A review of resident #007's plan of care for a period of 30 days in 2015, indicated that an assessment was not documented using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. In an interview with the DRC on an identified date in 2016, it was confirmed that resident #007's bladder continence was not assessed using an appropriate assessment instrument when their continence was identified to have worsened. The administrator confirmed that an assessment tool specifically designed for the assessment of incontinence had not been implemented in the home. (Inspector #583)

B) A review of resident #008's plan of care identified their bladder continence was assessed to have worsened. The MDS bladder continence assessment completed on an identified date in 2015, was coded as zero, indicating continent and the MDS assessment completed on the following quarterly assessment review was coded as one, usually continent. A review of resident #008's plan of care during an identified period of time in 2015, indicated that an assessment was not documented using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. In an interview with the DRC on an identified date in 2016, it was confirmed that resident #008's bladder continence was not assessed using an appropriate assessment instrument when their continence was identified to have worsened. The Administrator confirmed that an assessment tool specifically designed for the assessment of incontinence had not been implemented in the home. (Inspector #130). [s. 51. (2) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a written response was provided to Residents' Council within 10 days of when their advice was received related to concerns or recommendations.

During a review of the Resident Council meeting minutes and materials provided by the Manager of Recreation and Environmental Services it was identified that written responses were not provided to Residents' Council within 10 days of when residents provided advice at the council meeting. In an interview with the Manager of Recreation and Environmental Services on an identified date in 2016, it was confirmed that a process was not in place to provide a written response to Residents' Council within 10 days and that responses were usually provided at the next council meeting. [s. 57. (2)]

Issued on this 16th day of February, 2016

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

Original report signed by the inspector.