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
Direction de l'amélioration de la performance et de la conformité

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 # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2015	2015_323130_0001	H-001840-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

UPPER CANADA LODGE
272 WELLINGTON STREET P. O. BOX 1390 NIAGARA-ON-THE-LAKE ON L0S 1J0

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

GILLIAN TRACEY (130), CATHY FEDIASH (214), KELLY HAYES (583), MARILYN TONE (167), ROSEANNE WESTERN (508)

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 13, 14, 15, 16, 19, 20, 21 and 22, 2015

The following complaint inspections were conducted simultaneously with this RQI: H-001530-14 and H-001625-14. The following critical incident inspections were conducted simultaneously with this RQI: H-000746-14 and H-001633-14. The following follow-up was conducted simultaneously with this RQI: H-000619-14 r/t s.6(2)

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Resident Assessment Instrument (RAI) Coordinator, Manager of Dietary Services, Manager of Recreation Services, Administrative Assistant, Rehabilitation staff, Registered staff, personal support workers (PSW's), Dietary staff, maintenance staff, President of Residents' Council, residents and families.

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
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

8 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (2)	CO #001	2014_323130_0002	130

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. (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 care set out in the plan of care was provided to the resident as specified in the plan.

A) An interview with resident #005 indicated that they received showers and would prefer a bath. A review of the resident's tasks in the documentation system, Point of Care (POC) indicated under "task" that the resident preferred a tub bath. A review of the documentation in POC under, "What type of bath was given" was reviewed over a one month period in 2014 and 2015 and indicated that the resident received showers instead of a tub bath on each of their scheduled bath days. An interview with PSW's confirmed that the resident did receive showers. An interview with the DRC confirmed that the care set out in the plan of care was not provided to the resident as specified in their plan. (Inspector #214)

B) The plan of care for resident #002 indicated the resident required a specific physician ordered treatment. On an observed day in 2015, the resident was observed with the treatment being delivered; however, the treatment was not being delivered in accordance with the physician's order. Registered staff confirmed the treatment was not delivered as specified in the plan of care nor in accordance with the physician's order. Care was not provided in accordance with the plan of care. (Inspector #130)

C) It was observed by Inspector #130 and Inspector #508, on January 14, 2015, that resident #200 was served lunch in the dining room at 1200 hours. The resident's plan of care indicated that they required assistance for eating. The intervention required one staff to provide assistance which included constant cueing and assistance throughout

mealtimes. Resident #200 was served their lunch at 1200 hours; however, did not receive any assistance, including constant cueing, until 45 minutes after the lunch had been served. (Inspector #508) [s. 6. (7)]

2. The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) According to the plan of care, last reviewed in 2014, resident #002 received a physician's ordered treatment PRN (as needed). The resident was observed on two observed dates in 2015, and was noted to be receiving the treatment on both observed dates. Registered staff reported the resident had been receiving the treatment continuously at the request of family. The resident's family were interviewed and confirmed the resident had been receiving the treatment continuously for approximately one year. The resident's plan of care was not updated when their condition had changed. (Inspector #130)

B) The MDS (Minimum Data Set) Quarterly Assessments completed on two specified dates in 2014, for resident #003, indicated they had no difficulty making themselves understood and had no difficulty understanding others; had clear speech, adequate hearing and did not require any communication devices or techniques. The written plan of care revised in 2015, indicated the resident had an inability to express emotion and share information; had verbal alteration characterized by; decreased/lack of speech related to a decline in cognitive status. Interventions directed staff to assess for physical/non verbal indicators of discomfort or distress; ask the resident questions that required one or two word answers and encourage non verbal communication with the resident. Resident #003 was determined to be interviewable by Inspector #130. The DRC stated the written plan of care was put in place in 2014, but confirmed the communication plan had not been updated when the resident's communication had improved. (Inspector #130) [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 the care set out in the plan of care is provided to the resident as specified in the plan and that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times, including allowable exceptions to this requirement for a licensed bed capacity of 80 beds.

A) During an inspection of 24-hour nursing care, a review of the "Shifts with no RN coverage 2013 - 2014", indicated there was no Registered Nurse (RN) coverage on February 3, 2014, day shift, March 8, 2014, night shift, March 9, 2014, evening shift, April 5, 2014, night shift, May 31, 2014, night shift, June 23, 2014, evening shift, July 7, 2014, night shift, August 9, 2014, night shift, October 17, 2014, night shift and November 16, 2014, night shift. All of the identified shifts were 8 hours in length and the coverage was provided by a Registered Practical Nurse (RPN). In an interview with the DRC on January 22, 2015, it was confirmed that an RN was not on duty or present in the home on during these shifts on the the dates identified in the "Shifts with no RN coverage 2013 - 2014". (Inspector #583) [s. 8. (3)]

2. The licensee failed to ensure that during the hours that the Director of Nursing and Personal Care worked in that capacity, he or she was not considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection 8 (3) of the Act.

A) During an inspection of 24-hour nursing care, a review of the "Shifts with no RN coverage 2013 - 2014", indicated that on November 16 and December 30, 2014, the DRC provided RN coverage for 7.5 hours on the day shifts. In an interview with the DRC on January 21, 2015, it was confirmed that on November 16 and December 30, 2014, the DRC worked as both the one RN on duty and the Director of Nursing and Personal Care for 7.5 hours during the day shift. (Inspector #583) [s. 8. (4)]

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 at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, including allowable exceptions to this requirement for a licensed bed capacity of 80 beds and to ensure that during the hours that the Director of Nursing and Personal Care works in that capacity, he or she is not considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection 8 (3) of the Act, to be implemented voluntarily.

WN #3: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy : PRN (when needed) Administration and Documentation policy 8-4 indicated: Administer the medication to the resident and observe for effect; Document administration on Medication Administration Record (MAR) sheet including: time of administration, actual dosage given for orders with dosage ranges and initial in correct date column; Document nursing assessment and follow-up on Progress Notes, PRN Administration Record or on reverse side of the MAR sheet, according to the facility's

practice. Documentation to include: date, time, medication, dose, reason (as applicable to physician's order) medication was given, nurse's initial and effect, nurse's initials. For PRN medications given on a routine basis, ask the physician to consider changing the order to a routine order.

Resident #002 had a physician's order for a specified treatment PRN (as needed). The written plan of care directed staff to administer the treatment in accordance with the physician's order. Registered staff interviewed confirmed the physician's order was for PRN use, but verified the treatment was delivered continuously at the family's request. A review of the January MAR revealed that Registered staff had not signed for the administration of the treatment over a two week period in 2015. Staff had not documented the time it was administered, the dosage, the nursing assessment and follow-up, date, time, nor the reason for administration. Registered staff also confirmed they had not requested the physician's order be changed from PRN to routine. The home verified that it was the expectation that registered staff following the PRN Administration and Documentation policy 8-4, when administering this treatment PRN and confirmed this policy had not been followed with respect to resident #002. (Inspector #130)

B) A review of the 'Self-Administration of Medications' policy, in the Pharmacy Policy and Procedure Manual for LTC Homes, indicated that self-administration of medications by a resident is permitted when specifically ordered by the Physician who, with input from the nursing team, determines that the resident is capable of self-administering his/her own medications. These medications are stored in a secure area, inaccessible to other residents. The resident must sign a "Resident Self-Administration of Medication Agreement" which is to be filed in the resident's chart.

On a specified date in 2015, during an interview with resident #009, it was noted by the Inspector that the resident's medication was sitting on the resident's end table. When asked by the Inspector if that medication belonged to the resident, the resident indicated that it was their medication and they took it regularly. The resident indicated that the nurse had given it to them earlier, but they would take it themself at a specific time. During an interview with the nurse on duty, the nurse had indicated that she gave the medication to the resident to take later in the afternoon as the resident could self-administer the medication.

A review of the resident's clinical record indicated that self-administration had not been specifically ordered by the Physician nor was there an agreement for self-administration of medications.

An interview with Registered staff, indicated that the resident self-administers two other medications, not the medication observed on the night table.

It was confirmed by the RAI Coordinator and Registered staff that resident #009 did not have a physician's order or an agreement to self administer medications as directed in their policy.(Inspector #508)

C) The Manufacturer's instructions for the application of Wheelchair Seatbelts directed staff to "Secure the seatbelt across the patients hips firmly so you can fit only two fingers between the seatbelt and the patient's body". The home confirmed it was the expectation that staff follow these instructions when applying seatbelts.

On an observed date in 2015, resident #500 was observed with a loose fitting restraint applied. The device was loose enough to lift it above the chest and there was at least a five finger width spread between the resident's abdomen and the belt. Rehabilitation staff confirmed the device was too loose. (Inspector #130) [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure residents were offered a minimum of a between-meal beverage in the afternoon.

A) During an observation of the afternoon snack service on January 20, 2014, it was observed that residents who were off their units attending a program were not offered a between-meal beverage. In an interview with resident's #115, #400, #401, #402, at 1515 hours, it was shared they attended an afternoon program and were not offered and did not receive an afternoon between-meal beverage. In an interview with the Manager of Dietary/Housekeeping/Laundry and the recreational staff it was verified that residents were not offered a between meal beverage at the afternoon program and that resident #115, #400, #401 and #402 were not offered and did not receive and afternoon snack. (Inspector #583) [s. 71. (3) (b)]

2. The licensee failed to ensure residents were offered a minimum of a snack in the afternoon.

A) During an observation of the afternoon snack service on January 20, 2014, it was observed that residents who were off their units attending a program were not offered a snack. In an interview with resident's #115, #400, #401, #402, at 1515 hours, it was shared, they attended an afternoon program and were not offered and did not receive an afternoon snack. In an interview with the Manager of Dietary/Housekeeping/Laundry and the recreational staff it was verified that residents were not offered snacks at the afternoon program and that resident #115, #400, #401 and #402 were not offered and did not receive and afternoon snack. (Inspector #583) [s. 71. (3) (c)]

3. The licensee failed to ensure planned menu items were offered and available at each meal and snack.

A) A review of the January 20, 2014, planned snack menu indicated residents on puree texture would be offered a puree cookie. During an observation of the afternoon snack cart and service on January 20, 2014, residents on puree diet were observed being offered jello. In an interview with non registered staff it was shared, the puree cookie was unavailable and jello was being offered as the alternative. During the afternoon snack service on January 20, 2014, resident #007 was offered jello. A review of resident #007's plan of care and the snack cart diet list indicated the resident was to receive yogurt for afternoon snack. In an interview with the PSW's on January 20, 2014, they shared the yogurt was not available and resident #007 was offered jello as an alternative. In an interview with the Manager of Dietary/Housekeeping/Landry on January 20, 2014, it was confirmed the planned menu items of puree cookies and yogurt for resident #007 were not offered and available as per the planned menu. (Inspector #583) [s. 71. (4)]

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 residents are offered a minimum of a between-meal beverage in the afternoon, a minimum of a snack in the afternoon and to ensure planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #5: 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. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents, including residents #200 and #201, who required assistance with eating were served their meal when someone was available to provide assistance.

A) It was observed on January 16, 2014, by Inspectors #130 and #508, that staff had served lunch to residents #200 and #201 at 1200 hours. The staff continued serving residents their entrees and then started assisting other residents in the dining room with eating their meal and drinking their beverages. Residents #200 and #201 were lethargic and were sleeping intermittently throughout the lunch service and not eating their lunch. Staff continued to assist other residents with eating for 45 minutes after residents #200 and #201 had been served their food.

At 1245 hours, staff finished assisting other residents with their lunches. It was observed at this time that a staff member sat down with resident's #200 and #201 to assist them with eating. The resident's food had been served to residents #200 and #201, 45 minutes before assistance was provided. During an interview with PSW staff, the staff had indicated that they cannot assist all residents who require feeding at the same time. At times, residents will have to wait for assistance until they have finished assisting other residents.

A review of the Task Listing Report for two units of the home, including the unit that resident #200 and #201 resided on, indicated that in one unit 10 out of 20 residents required assistance with eating. In the other unit 5 out of 20 residents required assistance with eating.

A review of the staffing schedules for all four units of the home, indicated that during the lunch there were only two PSW staff available for each unit to assist residents with eating. (Inspector #508) [s. 73. (2) (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, including residents #200 and #201, who require assistance with eating are served their meal when someone is available to provide assistance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

A) Registered staff confirmed that medication packages, which contained residents' names and medication regimes, were discarded into a garbage bag, water was then added and the garbage bag was then discarded with the general garbage. Registered staff and the DRC confirmed that they could not guarantee that this method of disposal would ensure that the resident's personal health information would be protected. (Inspector #214) [s. 3. (1) 11. iv.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following were developed to meet the needs of residents with responsive behaviours: 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

A) Staff interviewed during this inspection and progress notes reviewed in the clinical record confirmed that resident #003, demonstrated specific responsive behaviours towards staff and co-residents. The RAI Coordinator verified there were no written strategies, techniques or interventions in place to prevent, minimize or respond to these responsive behaviours. (Inspector #130) [s. 53. (1) 2.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was notified when resident # 301 deceased after a fall which resulted in an injury.

A) Resident #301 sustained a fall in 2014, which resulted in an injury. The resident was transferred to hospital for treatment and returned to the home on an identified date in 2014.

The resident had a significant change in condition after their return from hospital with noted deterioration.

According to the clinical record, resident #301's condition continued to deteriorate until their death on a specified date later in 2014. The home submitted a critical incident related to the resident's injury but did not notify the Director when the resident deceased. The home confirmed the CI submitted to the Director was not amended as required. (Inspector #167) [s. 107. (1) 2.]

Issued on this 11th day of March, 2015

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

Original report signed by the inspector.