York Region
Infection Prevention and Control Lapse Report

Initial Report

Premises/Facility under investigation (name and address)
Woodbridge Square Dental Clinic
7600 Weston Road, Unit 49
Woodbridge, ON., L4L 8B7

Type of Premises/Facility
Clinical - Dental

Date Board of Health became aware of IPAC lapse (yyyy/mm/dd)	**Date of Initial Report posting (yyyy/mm/dd)**
2025/11/21	2025/12/03
Date of Initial Report update(s) (if applicable) (yyyy/mm/dd)	**How the IPAC lapse was identified**
	Referral

Summary Description of the IPAC Lapse

- Reusable semi-critical and critical dental instruments/devices were not sterilized between patients as required and in accordance with the "PIDAC Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings, 3rd Edition, May 2013".
- Dental instruments/devices that have been reprocessed were not clearly distinguished from those that had not been reprocessed, as required by the best practice standards in Infection Prevention and Control.
- Sterilized dental instruments/devices were not verified for chemical indicator (CI) colour change before use on patients, as required by the best practice standards in Infection Prevention and Control.

IPAC Lapse Investigation	**Yes**	**No**	**N/A**	**Please provide further details/steps**
Did the IPAC lapse involve a member of a regulatory college?	☒	☐	☐	Royal College of Dental Surgeons of Ontario (RCDSO) College of Dental Hygienists of Ontario (CDHO)
If yes, was the issue referred to the regulatory college?	☒	☐	☐	
Were any corrective measures recommended and/or implemented?	☒	☐	☐	
Please provide further details/steps	**Corrective measures for Premises/Facility:** • Monitor and verify sterilization verification processes, including physical, chemical, and biological indicators, prior to releasing dental instruments/devices for use on patients, in accordance with the "PIDAC Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings, 3rd Edition, May 2013". • Check and verify chemical indicators (CIs) for appropriate colour change before instruments/devices are used. Where a failed CI is found, reprocess the instruments/devices. • Implement a process to clearly differentiate dental instruments/devices that have been reprocessed from those that have not been reprocessed.			

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Date any order(s) or directive(s) were issued to the owner/operator (if applicable) (yyyy/mm/dd)
HPPA Section 13 Order issued on 2025/11/07.

Initial Report Comments:

HPPA Section 13 Order was issued on 2025/11/07, requiring the operator to correct procedures related to monitoring and verification of sterilization processes, including monitoring and verification of physical, chemical, and biological indicators, and to implement a system that clearly differentiates reprocessed instruments from those that have not been reprocessed.

Any additional Comments: (Please do not include any personal information or personal health information)

If you have any further questions, please contact:
Health Connection

Telephone Number	Email Address
1-800-361-5653	Health.inspectors@york.ca

Final Report

Date of Final Report posting (yyyy/mm/dd)
2025/12/03

Date any order(s) or directive(s) were issued to the owner/operator (if applicable) (yyyy/mm/dd)
HPPA Section 13 Order issued on 2025/11/07.

Brief description of corrective measures taken

Date of all corrective measures were confirmed to have been completed (yyyy/mm/dd)
2025/11/07

Final Report Comments and Contact Information

Any Additional Comments: (Please do not include any personal information or personal health information)

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