

Initial Report
Premises/Facility under investigation (name and address)

Jouvence Elite Aesthetics
202 - 4961 Highway 7
Markham, ON., L3R 1N1

Type of Premises/Facility

Personal Service Setting and Medical Aesthetic Services

Date Board of Health became aware of IPAC lapse (yyyy/mm/dd)

2026/07/24

Date of Initial Report posting (yyyy/mm/dd)

2026/08/17

Date of Initial Report update(s) (if applicable) (yyyy/mm/dd)
How the IPAC lapse was identified

Complaint

Summary Description of the IPAC Lapse

- Multidose vials, single-use vials, and single-use injectable gel implants were not used, handled, labelled, stored, maintained, and discarded in accordance with the product monograph, manufacturer's instructions for use and "PIDAC Best Practices for Infection Prevention and Control for Clinical Office Practice April 2015" on safe preparation and administration of injectables.
- Sterile medical supplies were not stored in a clean, dry, dust-free area and kept away from sinks, debris, drains, and moisture.
- Reusable equipment/instruments used for aesthetic procedures (e.g., treatment of skin concerns, scars, pigmentation, skin tightening, hair removal, and facials) were not cleaned manually using detergent or enzymatic cleaner and water or mechanically using an ultrasonic cleaner or a washer-disinfector.
- Reusable equipment/instruments used for aesthetic procedures (e.g., treatment of skin concerns, scars, pigmentation, skin tightening, hair removal, and facials) were not disinfected using a disinfectant solution that was appropriate for the intended use of the equipment/instruments.
- Reusable equipment/instruments used for aesthetic procedures that require sterilization were not being sterilized after each use.
- Hand hygiene was performed in a sink that was not dedicated for hand hygiene only.
- Alcohol-based hand rub products used on premises for hand hygiene were expired.

IPAC Lapse Investigation

Did the IPAC lapse involve a member of a regulatory college?

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If yes, was the issue referred to the regulatory college?

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The College of Physicians and Surgeons of Ontario (CPSO) and the College of Nurses of Ontario (CNO).

Were any corrective measures recommended and/or implemented?

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Please provide further details/steps

Corrective measures for Premises/Facility:

- Use, handle, label, store, maintain, and dispose of multidose vials, single-use vials, and single-use injectable gel implants according to the product monograph, manufacturer's instructions for use, and current best practices for the safe preparation and administration of injectables.
- Stop the practice of pre-filling-injectable products in advance, for their later use in accordance with "PIDAC

Infection Prevention and Control Lapse Report

		Best Practices for Infection Prevention and Control for Clinical Office Practice April 2015". • Store sterile supplies in a clean, dry, dust-free area, and keep them away from sinks, and protected from debris, drains, and moisture. • Clean, and disinfect or sterilize all reusable equipment/instruments as per manufacturer's instructions for use, and in accordance with the "Public Health Ontario: Guide to Infection Prevention and Control in Personal Service Settings, 3rd Edition, July 2019" or "Public Health Ontario: Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices In All Health Care Settings, 3rd edition, May 2013," as applicable. • Clean reusable tools manually using detergent, or enzymatic cleaner and water or mechanically using an ultrasonic cleaner or a washer-disinfector. • Prepare and use disinfectants that are intended and approved for disinfection of reusable equipment devices, ensuring the disinfectant selected is compatible with the tools being disinfected and holds a valid Health Canada Drug Identification Number (DIN) or Medical Device Active Licence Listing (MDALL). • Perform hand hygiene in a designated handwashing sink that is not used for any other purpose, or by using alcohol-based hand rub, when hands are not visibly soiled. • Use alcohol-based hand rub that is not expired.
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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 was issued on 2026/06/19.

Initial Report Comments:

An HPPA Section 13 Order was issued on 2026/06/19. The operator was ordered to stop the use of the Aquapeel Hydrofacial VSB device, Cynosure XERF system device, Cynosure PicoSure device, and Mesotherapy device. The operator was ordered to stop the provision of personal services that involve the use of equipment/devices requiring high-level disinfection or sterilization. The operator was ordered to ensure all reusable equipment/devices and instruments are cleaned, and disinfected or sterilized as per manufacturer's instructions for use and in accordance with the "Public Health Ontario: Guide to Infection Prevention and Control in Personal Service Settings, 3rd Edition, July 2019" or "Public Health Ontario: Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices In All Health Care Settings, 3rd edition, May 2013," as applicable. Cynosure Potenza device was placed on hold.

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

1-800-361-5653

Email Address

Health.inspectors@york.ca

Final Report

Date of Final Report posting (yyyy/mm/dd)

Date any order(s) or directive(s) were issued to the owner/operator (if applicable) (yyyy/mm/dd)



York Region
Infection Prevention and Control Lapse Report

Brief description of corrective measures taken

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

Final Report Comments and Contact Information

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

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