

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

Vaughan Medical Centre  
9000 Weston Road Unit 9 - Rm 5  
Vaughan, ON  
L4L 0L1

**Type of Premises/Facility**

Clinical – Foot Care

<b>Date Board of Health became aware of IPAC lapse (yyyy/mm/dd)</b> 2025/08/04	<b>Date of Initial Report posting (yyyy/mm/dd)</b> 2025/08/28
---	--

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

**Summary Description of the IPAC Lapse**

- Critical foot care equipment was not single-use, disposable or sterilized 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”.
- One-directional workflow for reprocessing was not maintained, posing a risk of equipment re-contamination during reprocessing.
- Reprocessed equipment was not stored in a manner that prevented contamination.

IPAC Lapse Investigation	Yes	No	N/A	Please provide further details/steps
Did the IPAC lapse involve a member of a regulatory college?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	College of Nurses of Ontario (CNO)
If yes, was the issue referred to the regulatory college?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Were any corrective measures recommended and/or implemented?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please provide further details/steps

**Corrective measures for Premises/Facility:**

- Clean and sterilize all reusable critical foot care equipment between each patient in accordance with the “PIDAC Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings, 3<sup>rd</sup> Edition, May 2013”.
- Establish and maintain a one-directional workflow for reprocessing.
- Store reprocessed equipment in a manner that prevents contamination.

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

HPPA Section 13 Order issued on 2025/08/01.

**Initial Report Comments:**

HPPA Section 13 Order was issued on 2025/08/01, requiring the operator to cease providing foot care services until conditions related to cleaning and sterilization of critical foot care equipment, reprocessing workflow, and storage of reprocessed equipment are corrected.



York Region

## Infection Prevention and Control Lapse Report

**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](mailto:Health.inspectors@york.ca)

---

### Final Report

---

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

2025/08/28

---

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

---

### Brief description of corrective measures taken

Re-inspection was conducted on August 26, 2025. Operator purchased, installed and qualified a Health Canada licensed sterilizer for reprocessing for reusable foot care equipment. Operator demonstrated the correct procedures for the cleaning and sterilization of critical foot care equipment, reprocessing workflow, and storage of reprocessed equipment. Operator was permitted to resume providing foot care services.

---

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

2025/08/26

---

### Final Report Comments and Contact Information

---

**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](mailto:Health.inspectors@york.ca)