GRAND ERIE
PUBLIC HEALTH

GEPH Infection Prevention and Control Lapse Report	
Initial Report	
Premise/facility under investigation (name and address)	Grand River Orthodontics | docbraces Simcoe 191 Queensway West Simcoe, Ontario N3Y 2M8
Type of premise/facility: (E.g. clinic, personal services setting)	Orthodontics office
Date Board of Health became aware of IPAC lapse	March 12, 2025
Date of Initial Report posting	April 7, 2025
Date of Initial Report update(s) (if applicable)	
How the IPAC lapse was identified	Inspection of clinic in Brantford owned and operated by the same staff.
Summary Description of the IPAC Lapse	Findings based on inspection in Brantford clinic: • At time of the investigation instrument/equipment manufacturer's instructions for use (MIFU's) were not available for review • Missing or incomplete documentation and sterilization logs (e.g., load items, tests for ultrasonic cleaner, etc.). • Internal integrators not used in some reprocessed items (e.g., IPR strips, green polishing stones). • Semi-critical items (i.e., hand piece motors) not high-level disinfected or sterilized. • Inconsistent disassembling of instruments (e.g., two-piece mouth mirrors) observed of the inspection. • Sterilized items (e.g., IPR strips, green polishing stones) with no type 5 integrator released prior to knowing the BI results for the day. • Some instruments did not follow the sterilization requirements and/or the time, temperature and pressure parameters set by the manufacturer. • During the complaint inspection it was observed that the disinfection and sterilization of reusable instruments on site

	did not follow Provincial Infectious Disease Advisory Committee (PIDAC) Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices (May 2013).
IPAC Lapse Investigation	
Did the IPAC lapse involve a member of a regulatory college?	Yes i) College of Dental Hygienists of Ontario (CDH) ii) Royal College of Dental Surgeons of Ontario (RCDSO)
If yes, was the issue referred to the regulatory college?	Yes
Were any corrective measures recommended and/or implemented?	Yes
Please provide further details/steps	• Facility is to provide the manufacturer's instructions for use (MIFU) of all instruments and equipment to review if sterilization parameters have been met. • Lines in the suction machines are to be flushed as per MIFU • Documentation to be completed in full. • Appropriate Personal Protective Equipment (PPE) is to be based of clinical risk assessment and available to staff. • Items are to be reprocessed as per the MIFU, accompanied with an internal integrator (i.e., type 4 or 5) • At minimum, high-level disinfect (sterilization is preferred) semi-critical items between use (i.e., hand piece motors). • If holding back the processed load/package is not possible, evaluation and documentation of a process challenge device (PCD) containing a Type 5 or 6 chemical indicators and checking, verifying and documenting the specific cycle physical parameters may be used to justify the release of routine loads.
Date any order(s) or directive(s) were issued to the owners/operators (if applicable)	March 19, 2025 and April 1, 2025
Initial Report Comments and Contact Information	
Any Additional Comments	
If you have any further questions, please contact:	
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Title	Program Manager, Infectious Disease
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Phone number	519-753-4937 ext. 251
Final Report	

Date of final report posting	
Date any order(s) or directive(s) were issued to the owner/operator (if applicable)	
Brief description of corrective measures taken	
Date all corrective measures were confirmed to have been completed	
Final report comments	
Final Report Contact Information. If you have any further questions, please contact	
Name	Filip Pajtondziev
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Phone number	519-753-4937 ext. 251