College of Pharmacists of Manitoba

NEWSLETTER

SUMMER 2026



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CPhM Developments

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Our purpose is to regulate the pharmacy profession with a commitment to excellence in person-centred, evidence-informed, and timely pharmacy care for all people. We serve the public interest by ensuring all pharmacy professionals are qualified to provide safe, ethical, and culturally sensitive care, free from all forms of racism, including Indigenous-specific racism. Through inclusivity, collaboration, and a dedication to integrity and accountability in our regulatory practices, we create an equitable environment that protects and prioritizes the public's best interests.

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The mandate of the CPhM is to serve and protect the public interest

This Newsletter is published four times per year by the College of Pharmacists of Manitoba (CPhM) and is forwarded to every pharmacy professional in the Province of Manitoba. Decisions of the CPhM regarding all matters such as regulations, drug-related incidents, etc. are published in the newsletter. The CPhM therefore expects that all pharmacy professionals are aware of these matters.

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Message from the Chair

Hello pharmacy professionals and members of the public,

As summer begins, many of us look forward to a season of rest, time with family, and opportunities to get outside and recharge. This year, however, the summer season has brough significant challenges for many communities across Manitoba. Wildfires continue to impact the north, while flooding has affected multiple communities across central and southern Manitoba, and is ultimately disrupting lives and placing added strain on healthcare services.

To the pharmacy professionals and pharmacy teams serving these communities, thank you. Whether you are responding to an increased demand or working to ensure patients continue to receive the medication and care they need, your dedication and resilience do not go unnoticed. On behalf of Council, I want to acknowledge the efforts you are making to support your patients and communities during this difficult time.

Over the last couple of months, the College of Pharmacists of Manitoba (CPhM) has remained busy with several initiatives including multiple consultations on proposed amendments to the Pharmaceutical Regulation and practice directions, education webinars, and the 148th Annual General Meeting (AGM) that occurred on May 12, 2026. Through these initiatives, CPhM continues to fulfill its legislated mandate to protect the public by strengthening the regulatory framework for pharmacy practice, supporting adherence to standards and requirements, and promoting the safe and effective delivery of pharmacy services across Manitoba.

As I begin my third year on Council, I am grateful for the opportunity to continue working alongside such a dedicated group of Council members and CPhM staff and I am honoured to continue my role as Chair of Council. I would also like to recognize and thank Brendon Mitchell and Teryl Moore, whose terms of service on Council concluded in May 2026. Their leadership and thoughtful participation strengthened Council's governance, supported effective decision-making, and contributed meaningfully to the regulation of pharmacy practice in Manitoba. At the same time, I am pleased to welcome Bhupendrasinh Chauhan and Suraj Sandil to Council, both of whom will serve a three-year term ending in 2029. I look forward to working with them and the rest of Council.



At the end of May, CPhM, along with members of the Quality Assurance (QA) Committee, Anu Okunnu Sampson (Chair) and Pat Trozzo, and Lead Consultant Dr. Nancy Winslade, hosted the first webinar for the Continuing Competency Program (CCP) project. This webinar was designed to provide an introductory overview of

the CCP project, the changes being considered to the CCP and the feedback received to date, and to answer registrants' questions about the proposed changes. A follow-up survey was conducted to obtain feedback from pharmacy professionals. The QA Committee used this information to guide its decisions regarding the CCP.

I encourage pharmacy professionals to continue reading the bi-weekly Friday Five, which includes regular updates in the Continuing Competency Matters section. Further, if pharmacy professionals would like to find out more about the CPP project or catch up on all the last Continuing Competency Matters, they can visit https://cphm.ca/continuing-competency-program-project/.

I wish you all a safe summer.

Sincerely,
Kathy Hunter

In Case You Missed It: CPhM Developments

Professional Development Opportunities

CPhM Mandatory Professional Development
CPhM Council approved communication as the theme for the mandatory learning activity for all pharmacy professionals that will span the 2026 and 2027 practice years. Through these seven videos, pharmacy professionals will examine key themes and topics, focusing on effective communication in pharmacy practice, including trends in CPhM complaints, the patient perspective, empathic communication, culturally sensitive communication, conflict, and de-escalation. To close out the video series, three of the subject matter experts engage in a panel case discussion. All videos must be viewed in full by October 31, 2027.

To learn more, visit https://cphm.ca/friday-five/friday-five-june-5-2026/#MandatoryPD.

Update to the Fundamentals of Prescribing for Manitoba Pharmacists
The Fundamentals of Prescribing for Manitoba Pharmacists presentation outlines the expanded scope of practice, including prescribing for self-limiting conditions, smoking cessation, and uncomplicated cystitis; administering drugs and vaccines by injection; ordering laboratory tests,* and, with the latest update, prescribing and administering drugs for hormonal contraception.*

While prescribing and administering drugs for hormonal contraception has not yet been implemented in Manitoba, pharmacists can now complete the required training in anticipation of these amendments taking effect.

To learn more about the latest update or to expand your scope of practice, visit https://cphm.ca/friday-five/friday-five-june-5-2026/#Updates.

*As of July 10, 2026, these expanded scopes of practice have not yet been implemented in Manitoba community pharmacies. Keep up to date with CPhM communications via the Friday Five and direct registrant messages from CPhM.

Strategic Plan Project Updates

Continuing Competency Project (CCP)
Council has approved the Visionary CCP Framework, marking an important milestone in the modernization of CPhM's CCP. The framework was influenced by feedback gathered through webinars, surveys, focus groups, system partner engagement, current evidence, and best practices.

Feeback received during the post webinar survey also highlighted the importance of reading CCP updates provided on the CPhM website and through Friday Fives. Responses from those who reviewed past editions of the *Continuing Competency Matte*r in the Friday Five demonstrated a clearer understanding of the proposed changes and the evidence informing them. As work on the CCP continues, pharmacy professionals are encouraged to continue reading the Friday Five and visiting the CCP webpage for all the latest information,

updates and resources.

Hospital Practice Directions Project
As mentioned in the July 3, 2026, Friday Five, the Needs Assessment (first phase) of the Hospital Practice Directions (HPD) Project has concluded. Through this phase, evidence was gathered to identify and understand patient safety hazards in hospital pharmacy practice in Manitoba, which will be used to develop recommendations for the new HPD and through other complimentary regulatory strategies.

Over the next year, sections of the new HPD will be drafted and Manitoba hospital pharmacists, pharmacy technicians, pharmacy managers and leaders will have opportunities to lend their expertise and nuance to foster effective, reasoned hospital pharmacy regulatory requirements.

For more information about the HPD, to read more about the Needs Assessment findings, and/or to submit feedback, please visit https://cphm.ca/cphm-hospital-practice-direction-hpd-project/.

Consultations

CPhM prioritizes the input and perspectives of the public, pharmacy professionals, and other community partners in Manitoba. Over the summer, CPhM will have multiple consultations open for feedback from pharmacy professionals, members of the public, and system partners. Consultations are how CPhM seeks feedback on proposed policies, guidelines, and initiatives aimed at enhancing the regulation of pharmacy practice in Manitoba. By engaging with diverse audiences, we ensure that decisions are well-informed and reflective of the needs and expectations of those we serve.

Your participation is invaluable in helping us fulfill our mandate to serve and protect the public interest in pharmacy practice.

Read the bi-weekly Friday Fives to keep up to date on the latest consultations or visit CPhM's dedicated consultation webpage. More information on open consultations and CPhM's consultation process can also be found here: https://cphm.ca/news-events-publications/consultations/.



Safety Feature:

The Importance of CQI: A Case Example

Ely Yatsun (PharmD) is a graduate of the College of Pharmacy, Rady Faculty of Health Sciences, University of Manitoba. He recently completed a fourth-year elective rotation with the College of Pharmacists of Manitoba, where he contributed to this work. Through his training in both hospital and community pharmacy settings, he has developed a strong understanding of pharmacy practice and the systems that support safe and effective patient care.

Continuous Quality Improvement (CQI) meetings are a key component of the Safety IQ program and play an essential role in identifying risks, analyzing medication incidents and near misses, as well as implementing system-level changes to improve patient safety. When used effectively, these meetings support proactive learning and help prevent harm. The following sample case highlights how ineffective use of a CQI meeting can result in missed opportunities to address known risks and ultimately lead to a preventable medication incident.

Importance of CQI

Background

A community pharmacy holds their required annual CQI meeting, but the meeting is rushed and treated as a formality rather than a meaningful safety discussion. Only a few staff members attend, and the team does not review recent medication incidents or near-miss events in detail. Incident data from the reporting platform is not analyzed, and no discussion occurs about previous improvement plans or trends in dispensing errors.

Situation

Over the past several months, the pharmacy has experienced multiple near-miss events involving similar patient names, where prescriptions were nearly dispensed to the wrong patient. These events were reported individually in the reporting system but were never discussed collectively during the CQI meeting. Since the team did not review

Latest from the Safety IQ Blog

The Safety IQ Blog features short, actionable articles to support continuous quality improvement in your pharmacy. Here are the latest posts:

- The Power of Apology: Building Trust Through Honest Conversations

  Explore the role of an apology in maintaining trust and confidence, outlining the principles of delivering meaningful and legally sound apologies under the Apology Act.

- Making CQI Meetings Matter: Strategies to Engage Your Team

  Explore techniques to foster active participation in CQI meetings, from setting clear agendas to creating a supportive environment that encourages all voices to be heard.

incident trends or develop an action plan, the underlying system issue, (patients with similar names in the software system) was never addressed.

Several weeks later, a prescription is dispensed to the wrong patient with the same name, and the error is not caught during counselling. The patient takes the medication before the mistake is discovered, resulting in a medication incident that required follow-up with the prescriber and monitoring for adverse effects.

Consequences

- A preventable medication incident reached the patient.
- The pharmacy team must perform additional follow-up and documentation due to this error.
- Trust between the patient and pharmacy may be affected.
- The pharmacy identifies that similar near-miss events had already occurred but were not acted upon during the CQI process.

Analysis

The incident could have potentially been prevented if the pharmacy had used the CQI meeting effectively to:

- Review medication incident and near-miss trends from the reporting platform.
- Discuss recurring risks and contributing factors.
- Develop and document an improvement plan to address the issue.

CQI meetings are intended to review incident data, assess improvement plans, and create new action plans based on safety trends. When these meetings are not used effectively, opportunities to identify system weaknesses and prevent harm may be missed.

Potential Corrective Actions

Following the incident, the pharmacy team:

- Conducts a comprehensive CQI meeting with full staff participation.
- Reviews the incident data summary and previous near-miss reports to identify patterns.
- Implements system changes such as bolding similar patient names in the software and confirming date of birth at prescription drop-off and counselling.
- Documents the discussion and action plan from the CQI meeting and assigns staff responsible for monitoring progress.
- Schedules regular quarterly reviews of incident and near-miss data to ensure issues are identified earlier.

The case above highlights the importance of CQI meetings in identifying contributing factors to near misses and medication incidents and developing strategies to prevent recurrence. Through structured analysis and discussions, CQI meetings support a culture of learning and patient safety. The findings of this case align with existing CQI data, reinforcing the value of system-based improvements, effective communication, and ongoing quality improvement efforts in pharmacy practice. For more information and data on Continuous Quality Improvement, visit https://safetyiq.academy/continuous-quality-improvement-meeting/.

Resources for Professional Development



Safety Measure

Data Reports from the NIDR

Data matters! Statistical reports from the National Incident Data Repository (NIDR) for Community Pharmacies highlight the common types of incidents and near-miss events in Manitoba, guiding the improvement efforts of pharmacy professionals and the College of Pharmacists of Manitoba (CPhM).

Here is a summary of the data reported by Manitoba's pharmacy professionals from April 1, 2025 to September 30, 2025:

- Pharmacy professionals have submitted 1382 reports to the NIDR
- Pharmacy professionals have reported 1005 medication incidents (medication dispensed and reached the patient) and 98 caused patient harm
- Pharmacy professionals reported 377 near-miss events

The top three incident types were:
• Incorrect dose/frequency
• Incorrect drug
• Incorrect strength/concentration

Please view the Safety IQ: 2025 Year in Review graphic for more details.

DISCIPLINE DECISIONS/SUSPENSIONS

Decision and Order of the Discipline Committee: Zubair Mohammed

Introduction

1. Pursuant to a Notice of Hearing dated August 17, 2023 (the "August 2023 Notice"), an amended copy of the August 2023 Notice dated January 5, 2026 (the "Amended August 2023 Notice"), and a Notice of Hearing dated May 24, 2024 (the "May 2024 Notice"), a hearing was conducted by the Discipline Committee (the "Discipline Committee") of the College of Pharmacists of Manitoba (the "College") at the offices of Thompson Dorfman Sweatman LLP, on January 15, 2026, with respect to charges formulated by the Complaints Committee of the College (the "Complaints Committee") alleging that Zubair Mohammed ("Mr. Mohammed"), being a pharmacist under the provisions of *The Pharmaceutical Act*, C.C.S.M. c. P60 (the "Act") and a registrant of the College, is guilty of professional misconduct, conduct unbecoming a member, having displayed a lack of knowledge or lack of skill or judgment in the practice of pharmacy or operation of a pharmacy, or any of the above, as described in section 54 of the Act.

2. A summary of the charges formulated by the Complaints Committee in the Amended August 2023 Notice and the August 2023 Notice is as follows.

3. At Shoppers Drug Mart #533 (the "Main St. Pharmacy"), Unit C - 1155 Main Street, Winnipeg, Manitoba, in the capacity of a pharmacist and/or pharmacy manager and/or pharmacy owner:

    1. On or about November 10, 2021, Mr. Mohammed engaged in practices without the requisite skill and knowledge and/or beyond his area of practice, and/or failed to take reasonable steps to ensure patient safety, in the preparation and administration of methadone for patients [redacted] and [redacted] in contravention of subsections 18(a), 78(1)(b), 83(e) and (g) of the *Pharmaceutical Regulation*, Man Reg 185/2013 (the "Regulation"), and Statements I and VII of the *Code of Ethics* (the "Code"), or any of them, in that Mr. Mohammed:

        a. compounded and dispensed a methadone dose for patients [redacted]" and [redacted], using a methadone solution previously prepared for another patient and/or patients and, in doing so, Mr. Mohammed:

            i. failed to maintain a compounding record in contravention of sections 56(1)12 and 113 of the Regulation, subsections 2.1.1 and 2.1.3 of the Practice Direction Standard of Practice #12 - Records and Info1mation (the "R&I PD"), and subsection 6.4 of the NAPRA Model Standards for Pharmacy of Compounding of Non-Sterile Preparations (the “NAPRA Standards”), or any of them; and/or

            ii. failed to conduct a final verification of the compound and formulation in contravention of section 6.6 of the NAPRA Standards;

        b. failed to confirm, and was unable to verify, the administration of the correct dose of methadone 88 mg to patient [redacted], and was unable to confirm if the patient was at risk of harm due to

overdose, in contravention of section 2.4 of Practice Direction: Administration of Drugs including Vaccines (the "Administration PD");

c. failed to confirm, and was unable to verify, the administration of the correct dose of methadone 95 mg to patient [redacted], and was unable to confirm if the patient was at risk of harm due to overdose, in contravention of section 2.4 of the Administration PD;

d. failed to expeditiously address and document medication errors in contravention of subsections 56(1)9 and 56(1)12 of the Regulation, and subsections 2.1.1 and 2.1.3 of the R&I PD, or any of them, in that Mr. Mohammed:

   i. failed to notify the prescriber upon discovery of the medication error in contravention of subsection 3.2.1.6 of the Practice Direction Standards of Practice #9: Medication Incidents and Near-Miss Events (the "Incidents PD");

   ii. failed to document conversations with staff, the involved patient, and the prescriber in contravention of section 3.2.6 of the Incidents PD;

   iii. failed to create and submit a medication incident report through the medication incident reporting platform in contravention of section 3.2.4.1 of the Incidents PD;

   iv. failed to develop and implement changes to the pharmacy processes to minimize a recurrence of a similar incident, in contravention of section 3.2.5.2 of the Incidents PD; and

   v. failed to maintain and produce for regulatory review the MOST Program Satellite Pharmacy Agreement which was in place for patient [redacted] on or about November 10, 2021, in contravention of subsection 56(1)12 of the Regulation, sections 2.1.1 and 2.1.3 of the PD R&I, and the Opioid Agonist Therapy Guidelines for Manitoba Pharmacists (the "OAT Guidelines"), or any of them; and

e. with respect to patient [redacted]:

   i. created an inaccurate prescription record for the prescription dated November 1, 2021, by associating incorrect clinic information for the prescriber in contravention of subsection 70(1)(b) of the Regulation; and

   ii. failed to maintain and produce for regulatory review a methadone witnessed dose log for the period October 28, 2021, to November 13, 2021, and/or the MOST Program Satellite Pharmacy Agreement in effect on or about November 10, 2021, in contravention of subsections 56(1)12 and 113 of the Regulation, sections 2.1.1 and 2.1.3 of the PD R&I, and the OAT Guidelines, or any of them.

2. On or about November 10, 2021, Mr. Mohammed failed to determine if a patient had experienced harm, in contravention of section 3.2.1.1 of the Incidents PD & Statement VII of the Code, or either of them.

3. Mr. Mohammed dispensed prescriptions with incorrect directions to patient , indicating methadone carry doses were to be provided to the patient [redacted] contrary to the prescriber's direction, approximately four times in contravention of subsections 70(1)(g), 71(1)(j), 78(1)(b), and 83 of the Regulation, and subsections 2.1.1 and 2.1.3 of the R&I PD, or any of them.

4. As a pharmacy manager, Mr. Mohammed failed to take reasonable steps to ensure that Mr. Mohammed and the pharmacists under his supervision were adequately trained and proficient in the provision of opioid agonist therapy ("OAT") in contravention of subsection 65(3) of the Regulation, and the OAT Guidelines, or either of them.

5. Mr. Mohammed failed to expeditiously address and document medication errors in contravention of subsections 56(1)9 and 56(1)12 of the Regulation, and subsections 2.1.1 and 2.1.3 of the R&I PD, or any of them, in that Mr. Mohammed:

    a. for an incident which occurred on approximately June 4, 2021, involving patient [redacted]":

        i. failed to create a medication incident report upon discovery and promptly submit on the medication incident reporting platform in contravention of section 3.2.6.1 Incidents PD, and sections 2.1.1 and 2.1.3 of the R&I PD, or any of them;

        ii. failed to document CQI improvement plans, communications with prescriber, patient and staff as required by section 3.2.6 of the Incidents PD;

        iii. failed to develop and implement changes to the pharmacy processes to minimize recurrence of a similar incident in contravention 3.2.5.2 of the Incidents PD;

    b. for an incident or incidents which occurred between approximately June 4, 2021, and June 9, 2021, on approximately three occasions involving patient [redacted]

        i. failed to create a medication incident report upon discovery and submit promptly on the medication incident reporting platform in contravention of section 3.2.6.1 Incidents PD, and sections 2.1.1 and 2.1.3 of the R&I PD, or any of them;

        ii. failed to document CQI improvement plans, communications with prescriber, patient and staff as required by section 3.2.6 of the Incidents PD;

        iii. failed to develop and implement changes to the pharmacy processes to minimize recurrence of a similar incident in contravention of section 3.2.5.2 of the Incidents PD;

    c. for an incident which occurred on approximately August 23, 2021, involving patient[redacted]:

        i. failed to document the required conversations with the patient and/or prescriber in contravention of section 3.2.6 of the Incidents PD;

        ii. failed to develop and implement changes to the pharmacy processes to minimize recurrence of a similar incident in contravention of section 3.2.5.2 of the Incidents PD;

    d. for an incident which occurred on approximately January 26, 2023, involving patient [redacted]":

        i. failed to notify the prescriber upon discovery of the medication error in contravention of section 3.2.1.6 of the Incidents PD.

6. Mr. Mohammed failed to secure narcotic and controlled drug substance inventory in contravention of section 43 of the *Narcotic Control Regulations*, C.R.C., c. 1041, (the "NCRs"), subsection G.03.012 of the *Food and Drug Regulations*, C.R.C., c. 870 (the "FDRs"), and subsection 72(1)(a) of the *Benzodiazepines and Other Targeted Substances Regulations*

(SOR/2000-217) (the "BOTSRs"), and section 2.3.1 of the Practice Direction: Drug Distribution and Storage (the "DDS PD"), in that Mr. Mohammed:

a. on or about June 1, 2021, failed to conduct a narcotic and controlled substance count when commencing as pharmacy manager jointly with the out-going manager in contravention of the Narcotic and Controlled Drug Accountability Guidelines (the "Accountability Guidelines");

b. on or about December 27, 2021, failed to conduct a narcotic and controlled substance count jointly with the incoming manager in contravention of the Accountability Guidelines;

c. between approximately June 1, 2021, and December 27, 2021, failed to maintain a perpetual inventory of Methadose™ 10 mg/mL concentrate and Methadose™ SF 10 mg/mL concentrate in contravention of section 2.3.2.1 of the DDS PD and the Accountability Guidelines, or either of them;

d. between approximately June 1, 2021, and December 27, 2021, failed to conduct a physical inventory count of Methadose™ 10 mg/mL concentrate and Methadose™SF 10 mg/mL concentrate every three months in contravention of section 2.3.2.2 of the DDS PD, and the Accountability Guidelines, or either of them;

e. on approximately 150 occasions between June 19, 2021, and November 21, 2021, failed to investigate discrepancies in the narcotic and/or controlled drug inventory in contravention of sections 2.3.2.3 and 2.3.2.4 of the DDS PD, or either of them;

f. on multiple occasions between June 19, 2021 and November 21, 2021, failed to submit Loss and Theft Reports for Controlled Substances and Precursors to the Office of Controlled Substances, Health Canada, in contravention of section 42 of the NCRs, section G. 03.013 of the FDRs, subsection 72(2) of the BOTSRs, and/or section 2.3.2.5 of the DDS PD, or any of them;

g. on multiple occasions between June 19, 2021, and November 21, 2021, failed to submit Loss and Theft Reports for Controlled Substances and Precursors to the College, in contravention of section 2.3.2.5 of the DDS PD;

h. failed to keep narcotic and controlled substance accountability records in a clear, concise, and easily readable format which facilitates ease of use and regulatory review in contravention of sections 2.1.1, 2.1.2, and 2.1.3 R&I PD, or any of them;

i. on approximately three occasions between April 21, 2022, and March 15, 2023, failed to securely store the drug inventory in a narcotic safe in contravention of sections 2.2.8, and 2.2.15 of the Practice Direction: Standard of Practice # 15: Pharmacy Facilities (the "Facilities PD"), and/or the Accountability Guidelines, or any of them.

7. Mr. Mohammed failed to establish, implement and/or maintain, sufficient written policies and procedures ("P&P") in contravention of subsection 56(1)13 of the Regulation in that Mr. Mohammed failed to:

a. ensure accurate patient profiles, in contravention of section 2.1 of the Practice Direction: Patient Profiles (the "Profiles PD") and Minimum Pharmacy Policy and Procedures Manual Guideline, or either of them;

b. establish and implement sufficient site-specific P&P for the preparation and administration of OAT in contravention of subsection 56(1)5 of the Regulation, section 2.2 of the Administration PD, and the OAT Guidelines, or any of them;

c. establish and implement P&P to expeditiously address and document medication incidents in contravention of subsections 56(1)9 and 56(1)12 of the Regulation, and sections 3.1.1 and 3.2.3.4 of the Incidents PD, or any of them;

d. implement and maintain adequate P&P to secure and manage narcotic and controlled drug inventory in contravention of subsection 56(1)9 of the Regulation and section 2.3.2 of the PD DDS, or either of them;

e. implement and maintain P&P for the assessment and use of technology that ensured safe and effective pharmacy practice in contravention of subsection 56(1)16 of the Regulation;

f. implement and maintain P&P for patient counselling in contravention of sections 56(1)1, 56(1)16 and 73 of the Regulation and section 3.0 of the Patient Counselling Practice Direction, or any of them;

g. implement and maintain P&P for retaining accurate pharmacy records in contravention of sections 2.1.3 and 2.3.1.2 of the R&I PD, or any of them.

8. Mr. Mohammed failed to ensure that the Pharmacy was adequately staffed to enable safe and effective practice to meet patient health care needs in contravention of subsection 56(1)14 the Regulation, and Statement III of the Code, or either of them.

9. Mr. Mohammed failed to maintain and produce for regulatory review the following records in contravention of subsections 56(1)12 and 113 of the Regulation, sections 2.1.1 and 2.1.3 of the PD R&I, and the OAT Guidelines, or any of them, including:

   a. a methadone witnessed dose log for patient [redacted], for the period February 17, 2021, to March 6, 2021;

   b. a methadone witnessed dose log for patient [redacted], for the period September 26, 2021, to November 30, 2021, and/or the MOST Program Satellite Pharmacy Agreement, in effect on or about November 10, 2021.

10. Between June 9, 2021, and November 11, 2021, on approximately three occasions, Mr. Mohammed failed to inform patients of a breach of their personal health information in contravention of section 2.7.1.3 of the PD R&I and Statement IV of the Code, or either of them.

4. A summary of the charges formulated by the Complaints Committee in the May 2024 Notice is as follows.

5. At Shoppers Drug Mart #557 (the "Morden Pharmacy"), 302 North Railway Street, Morden, Manitoba, in the capacity of a pharmacist and/or pharmacy manager and/or pharmacy owner:

   1. Between July 9, 2021, and March 18, 2022, Mr. Mohammed authorized prescription refills for patient [redacted] utilizing incorrect prescriber information in contravention of sections 70(1) and 83 of the Pharmaceutical Regulation, Man Reg 185/2013 (the "Regulation"), and section 2.1.3 of the Practice Direction –Records and Information (the "Records PD"), or any of them.

2. As pharmacy manager, Mr. Mohammed failed to implement written policy and procedures with respect to creation of the prescription record and the final check process, for both new and refill prescriptions in contravention of section 56(1)13 of the Regulation.

3. On or about June 24, 2022, Mr. Mohammed failed to confirm the prescriber's address and contact information prior to faxing a second refill authorization request for patient [redacted] in contravention of section 83 of the Regulation;

4. On or about June 20, 2022, and June 24, 2022, Mr. Mohammed failed to follow up with patient [redacted], and/or the prescriber, about the outstanding prednisone refill authorization request in contravention of sections 2.2.1, 2.2.4 and 2.3 of the Practice Direction – Ensuring Patient Safety (the "Patient Safety PD") and Statement VII of the Code of Ethics (the "Code"), or any of them.

5. As pharmacy manager, Mr. Mohammed failed to establish, implement, and maintain written policies and procedures with respect to continued care refill authorizations in contravention of section 56(1)13 of the Regulation.

6. As pharmacy owner, Mr. Mohammed failed to implement sufficient written pharmacy policies and procedures with respect to patient counselling in contravention of sections 56(1)1, 56(1)13 and 73 of the Regulation, and sections 2.2.1, 2.14, 3.1 and 3.2 of the Practice Direction – Patient Counselling (the "Counselling PD"), or any of them.

7. As pharmacy owner, Mr. Mohammed failed to ensure that patient counselling and patient counselling refusals were documented in contravention of sections 56(1)1, 56(1)13 and 73 of the Regulation, and sections 2.2.1, 2.14, 3.1 and 3.2 of the Counselling PD, or any of them.

8. In or around July 2022, Mr. Mohammed failed to address, document, and report to the pharmacy manager, and to a national incident database, the circumstances around the Pharmacy's inability to provide patient [redacted] with [redacted] medication refills in contravention of subsection 56(1)9 of the Regulation, and sections 3.2.1.5, 3.2.3.1 and 3.2.4.1 of the Practice Direction – Medication Incidents and Near-Miss Events (the "Incidents PD"), or any of them.

9. In or around July 2022, Mr. Mohammed failed to inform and apologize to patient [redacted] for the medication incident in contravention of section 3.2.2.1 and 3.2.3.3 of the Incidents PD, or either of them.

10. 10. On or about June 24, 2022, Mr. Mohammed faxed protected patient health information to individuals who were not involved in the care of patient [redacted]" in contravention of Statement IV of the Code.

11. On or about March 7, 2022, Mr. Mohammed failed to review patient "[redacted]'s" fentanyl prescription, and failed to ensure the drug provided was appropriate, was the correct dose, was the correct route of administration, was the correct dosage form, was not a therapeutic duplication, and was provided consistent with the standards of care and patient safety in contravention of section 83 of the Regulation, and sections 2.1, 2.2.1, 2.2.2 and 2.2.4 of the Patient Safety PD, or any of them.

12. On or about March 7, 2022, Mr. Mohammed failed to consult with the prescriber with respect to any of the unfamiliar fentanyl dosage form, the rapid opioid dose escalation, and the therapeutic duplication of the long-acting forms of fentanyl and hydromorphone for patient [redacted] in contravention of section 83 of the Regulation, sections 2.1, 2.2.1, 2.2.2, 2.2.4 of the

Patient Safety PD, and Statement II of the Code, or any of them.

13. As pharmacy manager, Mr. Mohammed failed to conduct joint controlled substance physical counts upon change of pharmacy manager in contravention of the Narcotic and Controlled Drug Accountability Guidelines (the "Guidelines").

14. As pharmacy owner, Mr. Mohammed failed to ensure that controlled substance counts were conducted properly and accurately in contravention of section 43 of the Narcotic Control Regulations, C.R.C., c. 1041, (the "NCRs"), section G.03.012 of the Food and Drug Regulations, C.R.C., c. 870 (the "FDRs"), subsection 72(1)(a) of the Benzodiazepine and Other Targeted Substances Regulation, SOR/2000-217 (the "BOTSRs"), sections 2.3.1 and 2.3.2 of the Practice Direction – Drug Distribution and Storage (the "DDS PD"), sections 2.1.1, 2.1.2 and 2.1.3 of the Records PD, and the Narcotic and Controlled Drug Accountability Guideline (the "Guidelines"), or any of them.

15. As pharmacy manager and/or owner, on multiple occasions between May 2021 and October 2023, Mr. Mohammed failed to ensure that all discrepancies in the perpetual inventory were investigated and the investigations documented in contravention of sections 2.3.2.3 and 2.3.2.4 of the DDS PD, sections 2.1.1, 2.1.2 and 2.1.3 of the Records PD, and the Guidelines, or any of them.

16. As pharmacy manager and/or owner, on multiple occasions between May 2021 and October 2023, Mr. Mohammed failed to ensure all unexplained shortages were reported to Health Canada's OCS in contravention of section 42 of the NCRs, section G.03.013 of the FDRs, subsection 72(2) of the BOTSRs, section 2.3.2.5 of the DDS PD, and the Guidelines, or any of them.

17. As pharmacy manager and/or owner, on multiple occasions between May 2021 and October 2023, Mr. Mohammed failed to ensure all unexplained shortages were reported to the College in contravention of section 2.3.2.5 of the DDS PD and the Guidelines, or either of them.

6. The hearing into these charges convened on January 15, 2026. Mr. Jeffrey Hirsch and Ms. Sharyne Hamm appeared as counsel for the Complaints Committee. Ms. Jennifer Sokal appeared as counsel for Mr. Mohammed, who also attended in person. Mr. Thomas Reimer appeared as counsel for the presiding panel of the Discipline Committee (the "Panel").

7. The Complaints Committee and Mr. Mohammed jointly submitted a Statement of Agreed Facts (the "Statement"), which was entered into evidence as Exhibit 1. In the Statement, Mr. Mohammed admitted the following, with respect to jurisdiction, service, panel composition and practice and discipline history:

I. Jurisdiction, Service and Panel Composition

i. He is a member of the College.

ii. He received valid service of the August 2023 Notice, the Amended August 2023 Notice, and the May 2024 Notice.

iii. The College has complied with the requirements of ss. 46(2) and 46(3) of the Act.

iv. He has no objection to any of the Panel members, nor to legal counsel to the Panel, on the

basis of bias, a reasonable apprehension of bias, or conflict of interest.

II. Practice and Discipline History

v. Mr. Mohammed graduated with his pharmacy degree from Kakatiya University in India in 1996. He subsequently graduated from Kakatiya University with a Masters in Pharmacology in 1999.

vi. Mr. Mohammed has been registered as a pharmacist under the Act since October 12, 2010. At all times material to this proceeding, Mr. Mohammed was a member of the College as a practicing pharmacist in Manitoba.

vii. Mr. Mohammed's employment history as a pharmacist is as follows:

a. Prior to his immigration to Canada in August 2008, Mr. Mohammed worked for six years as a hospital pharmacist in the Middle East and for several years as an Associate Professor in the pharmacy department of a university in India.

b. From August to October 2010, Mr. Mohammed interned at Shoppers Drug Mart in Winkler, Manitoba.

c. From October 2010 to July 17, 2011, Mr. Mohammed worked as a staff pharmacist at the Shoppers Drug Mart in Winkler.

d. On July 17, 2011, Mr. Mohammed became owner of the Morden Pharmacy through his holding company, Danish Zubair Pharmacy Ltd.

e. From July 17, 2011, to June 1, 2021, Mr. Mohammed was pharmacy manager of the Morden Pharmacy.

f. In or around February 2021, Mr. Mohammed purchased the Main St. Pharmacy.

g. Mr. Mohammed took an emergency medical leave between May 5 and June 21, 2021.

h. On June 1, 2021, Mr. Mohammed resigned as pharmacy manager at the Morden Pharmacy to become the pharmacy manager at the Main St. Pharmacy.

i. Mr. Mohammed ceased being the pharmacy manager at the Main St. Pharmacy on or about December 27, 2021.

j. Between December 27, 2021, and the present, Mr. Mohammed has worked as a pharmacist at each of the Main St. Pharmacy and the Morden Pharmacy.

k. Mr. Mohammed has remained the owner of both the Main St. Pharmacy and the Morden Pharmacy, through his holding company.

viii. Mr. Mohammed has no previous discipline history with the College.

III. Admissions and Plea

8. Mr. Mohammed admitted to having reviewed the August 2023 Notice, the Amended August 2023 Notice, and the May 2024 Notice, as well as the Statement, which was signed by his counsel and

by counsel for the Complaints Committee. At the hearing he waived the reading of the charges. Mr. Mohammed admitted the truth and accuracy of the facts in the Statement and that the witnesses and other evidence available to the Complaints Committee would, if called and otherwise tendered, be substantially in accordance with the facts in the Statement.

9. 9. Mr. Mohammed tendered no evidence and made no submissions on the issue of professional misconduct, other than to admit that the conduct described in the Statement demonstrates professional misconduct as described in section 54 of the Act.

10. Mr. Mohammed entered a guilty plea to counts 1, 2, 3, 4, 5(a)(i), 5(a)(ii), 5(a)(iii), 5(b)(i), 5(b)(ii), 5(b)(iii), 5(c)(ii) 5(d)(i), 6, 7(b), 7(c), 7(d), (7e), 7(f), 7(g), 8, 9 and 10 in the Amended August 2023 Notice.

11. Mr. Mohamed entered a guilty plea to counts 2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16 and 17 in the May 2024 Notice.

12. These counts to which Mr. Mohammed has pled guilty are collectively referred to below as the "Charges".

13. The Complaints Committee entered a stay of proceedings with respect to counts 5(c)(i) and 7(a) of the Amended August 2023 Notice and with respect to counts 1, 3 and 10 in the May 2024 Notice.

14. Mr. Mohammed agreed that his admissions and guilty pleas were voluntary, informed and unequivocal. He also confirmed that he understood that by pleading guilty, he has given up his right to contest the factual accuracy of the allegations made against him in the Charges.

15. Mr. Mohammed agreed that, with respect to the Charges, his conduct constituted professional misconduct, a breach of the legislation, practice directions and guidelines (as particularized in the Charges), and a display of a lack of knowledge, skill or judgment in the practice of pharmacy or the operation of a pharmacy.

IV. Disposition

16. Legal counsel for the Complaints Committee and for Mr. Mohammed made a partial joint recommendation with respect to an appropriate disposition on penalty. As discussed below, the Panel accepts the partial joint submission with respect to the matters it addresses.

17. 17. The partial joint recommendation addresses all aspects of penalty except for whether a suspension should be imposed on Mr. Mohammed, and if so, the length of the suspension. The partial joint submission also does not address the issue of a contribution to costs. These issues were the subject of submissions from each of the Complaints Committee and Mr. Mohammed.

V. Decision and Order

18. Considering the evidence contained in the Statement, together with Mr. Mohammed's admissions of guilt, the Panel accepts that the Charges have been established. It therefore finds Mr. Mohammed guilty of professional misconduct, as described in s. 54 of the Act, and makes the following orders, pursuant to ss. 55 and 56 of the Act:

    a. Mr. Mohammed is to be suspended for four months, which suspension is to begin within 30

days of the date of this decision;

b. Mr. Mohammed is to pay a fine of $22,000.00;

c. after completion of the suspension, Mr. Mohammed is to have a restriction on his pharmacist licence that will prohibit him from becoming a pharmacy manager or preceptor for a period of two years;

d. prior to becoming a pharmacy manager in the future, Mr. Mohammed is to be required to complete the College's Pharmacy Manager Training Program; and

e. there will be publication of the conviction, penalty and circumstances of the offences, including publication of Mr. Mohammed's name.

19. Mr. Mohammed is ordered to pay a contribution toward the costs of the investigations and hearing in the amount of $35,000.00.

20. Mr. Mohammed will have five years from the date of this decision to pay the fine and contribution to costs.

VI. Reasons

21. In reaching its decision, the Panel considered the Statement, the partial joint recommendation, the submissions of the parties, the affidavit of Dr. Brent Booker affirmed January 15, 2026, and the affidavit of [redacted] affirmed January 14, 2026.

22. These reasons will deal separately with the issues of acceptance of the partial joint recommendation, suspension and costs, following a short summary of the facts and background that gave rise to the Charges.

A. Summary of Facts

23. Although the Panel has read, considered and accepted the Statement in its entirety, the facts and background section in the Statement, which is nearly 70 pages long, will not be reproduced in this decision. The following is a summary of the facts relating to the various Charges.

<u>Amended August 2023 Notice</u>

24. The Charges in the Amended August 2023 Notice relate to misconduct by Mr. Mohammed at the Main St. Pharmacy.

Count 1 – Patients [redacted] & [redacted]

25. On November 10, 2021, Mr. Mohammed compounded and dispensed methadone doses for patients [redacted] and [redacted]. He has admitted that when he did so, he engaged in practices without the requisite skill and knowledge and beyond his area of practice and failed to take reasonable steps to ensure patient safety. He has further admitted that his conduct breached the provisions of the Regulation, the Code and various other practice directions and professional standards identified in count 1 of the Amended August 2023 Notice and its subcharges.

26. When Mr. Mohammed became Associate Owner of the Main St. Pharmacy in February 2021, all

methadone prescriptions, whether for daily witnessed doses or carry doses, were pre-measured, mixed with orange Tang and stored in a fridge awaiting patient pick-up. Mr. Mohammed changed this practice in August 2021, after which only carry doses continued to be pre-measured and mixed with Tang. The primary reason he made this change was to reduce costly waste. Mr. Mohammed also began to use pre-mixed doses missed by patients for the preparation of doses for other patients.

27. On November 9, 2021, another pharmacist mixed three individual doses for another patient. That patient's prescription was cancelled the same day, but the doses were left in the fridge overnight. On November 10, 2021, Mr. Mohammed reused two of the three doses to prepare methadone doses for [redacted] and [redacted] However, he misunderstood the information on the pharmacy label, which caused him to prepare methadone doses that were significantly stronger than these patients' prescriptions. Mr. Mohammed witnessed the ingestion of the two doses by each of [redacted] and [redacted]

28. Mr. Mohammed kept no record of the steps he took or the calculations he performed to modify the pre-measured doses. He did not maintain a compounding record of these doses, and he failed to conduct a final verification of the compound and formulation of these doses, in breach of his obligations. Because of his failure to record or document his compounding steps and calculations, when the medication error was identified, it was not possible to determine the precise amount of methadone that [redacted] and [redacted] had ingested.

29. Although Mr. Mohammed could not recall exactly what he had done to modify the pre-measured doses for [redacted] and [redacted] he believed that he likely added 4.6 mL (46 mg) of methadone concentrate to the dose for [redacted] to bring it up what he thought was 88 mg. If this adjustment was made, [redacted] would have received 186 mg of methadone. Mr. Mohammed believes he likely added 5.3 mL (53 mg) of methadone concentrate to the dose for [redacted] to bring it up to what he thought was 95 mg. If this adjustment was made, [redacted] would have received 193 mg of methadone. These adjustments would have resulted in each of the patients ingesting more than double their prescribed dose of methadone.

30. Mr. Mohammed then failed, among other things, to properly document his conversations with staff, the involved patients and the prescribers about the medication error, failed to create and submit medication incident reports through the medication incident reporting platform, and failed to develop and implement changes to pharmacy processes to minimize the risk of recurrence.

31. After being unable to reach the patients by phone, and given that he, by estimate, had given them each a significantly increased dose, Mr. Mohammed delivered two naloxone kits to the patients' home. They advised him that they did not feel any signs of methadone overdose and Mr. Mohammed observed them in that moment to appear fine. He explained that he may have made a medication error and left them with the naloxone kits and with instructions to call him and/or 911 if they began to feel negative effects.

32. Although Mr. Mohammed made several calls to the patients later that evening, he did not document the calls, nor did he document any of the actions he took in response to the medication error. He did not contact the patients' prescribers until the next day, the Remembrance Day holiday, when he sent faxes to the two prescribers' clinics. One of the faxes was sent to the wrong clinic.

33. Mr. Mohammed did not seek guidance from the prescribers about potential adjustments to the methadone doses for the two patients for November 11 and 12. He administered the full prescribed doses to each patient on November 11.

34. Mr. Mohammed stated that he apologized to [redacted] and [redacted] during subsequent visits to during subsequent visits to the pharmacy. However, he did not document the apology, as required.

35. Although Mr. Mohammed stated there was a pharmacist huddle, there is no evidence of any policy or procedure change stemming from this serious incident.

36. Mr. Mohammed was unable to produce required documents, including a methadone witnessed dose log for one of the patients, in contravention of the Regulation, the Records PD and the OAT Guidelines.

Count 2

37. Count no. 2 relates to a third methadone dose reused by Mr. Mohammed on November 10, 2021. Mr. Mohammed could not remember if he reused that dose for one or multiple patients. He could not determine which patient or patients he gave the wrong dose to. Although he advised the College's investigator that he made some attempts to identify patients who may have been harmed, he did not document the steps he took, nor did he contact any of the OAT prescribers in the area to determine if any of their patients had reported experiencing adverse effects. As set out in count no. 2, this conduct breached the Incidents PD and the Code.

Count 3

38. Mr. Mohammed dispensed prescriptions with incorrect directions to a patient, indicating that methadone carry doses were to be provided to the patient, which was contrary to the prescriber's direction. On approximately four occasions, Mr. Mohammed filled the patient's methadone prescription and completed the final check process without noting that the instructions permitting the patient to carry doses were incorrect. This was a breach of the Regulation and the Records PD, as specified in count no. 3.

Count 4

39. As pharmacy manager of Main St. Pharmacy, Mr. Mohammed failed to take reasonable steps to ensure that he and the pharmacists under his supervision were adequately trained and proficient in the provision of opioid agonist therapy (OAT), which breached the Regulation and the OAT Guidelines. Mr. Mohammed and three other pharmacists working at the Main St. Pharmacy had not completed any accepted OAT training at the time of the complaints.

Count 5

40. Count 5 relates to Mr. Mohammed's failure to address and document medication errors as required by the Regulation and the Records PD.

41. A medication incident is a preventable occurrence or circumstance that may have led to inappropriate medication use or to patient harm. Pharmacists and pharmacy managers are required by legislation to report, document and analyze medication incidents. This must be done expeditiously by any pharmacist who becomes aware of a medication incident, not just the pharmacist involved or the pharmacy manager.

42. Counts 5(a), (b), and (c) each relate to a failure by Mr. Mohammed to properly report and document medication incidents at Main St. Pharmacy that either occurred, or were reported, while Mr. Mohammed was pharmacy manager.

43. Count 5(d) relates to a mistaken failure to provide a prescribed anti-platelet medication to a patient following cardiac surgery. After going without the prescribed medication for an undetermined time, the patient suffered a thrombotic event that required further surgery to address. This incident was reported to Mr. Mohammed, then the pharmacy owner and a staff pharmacist, and he investigated but failed to properly address, document or report. Notably, he took no steps to notify the prescriber.

Count 6

44. Count 6 and its nine subcounts relate to a series of failures by Mr. Mohammed to secure narcotic and controlled drug substance inventory at the Main St. Pharmacy in contravention of the regulations and practice directions outlined in the count. Two pharmacists who, at different times, had served as pharmacy manager at the Main St. Pharmacy, advised the College's investigator that even when he was no longer pharmacy manager, Mr. Mohammed retained full, or partial, control over narcotic counts and other narcotic accountability practices, including investigating discrepancies and shortages.

45. t the beginning and the end of his tenure as pharmacy manager, Mr. Mohammed was required by the Narcotic and Controlled Drug Accountability Guidelines (the "Accountability Guidelines") to conduct a narcotic and controlled drug substance count jointly with the outgoing or incoming pharmacy manager. This is an important practice because it establishes a formalized process for counting and documenting the physical inventory of all controlled substances within the pharmacy which are being transferred to the incoming pharmacy manager's possession and oversight. Mr. Mohammed failed to do that.

46. Mr. Mohammed also failed to do physical counts of methadone concentrate, something he was required to do at least quarterly. The reason regular physical counts of these kinds of drugs are required is to detect and prevent diversion and to assist in the investigation or assessment of medication errors. Mr. Mohammed acknowledged that he had never physically measured the methadone concentrate volumes at the Main St. Pharmacy during monthly narcotic counts, meaning that the on-hand volumes had never been verified. Instead, Mr. Mohammed appears to have prepared count reports where he simply wrote the expected or estimated amount, without physically measuring.

47. While he was pharmacy manager at Main St. Pharmacy, Mr. Mohammed also failed to investigate discrepancies in the narcotic counts, in contravention of the DDS Practice Direction. Investigating such discrepancies is required because it assists in detecting dispensing errors, receiving errors and drug diversion and plays an important role in narcotic accountability. Of the 150 discrepancies identified in the narcotic counts during Mr. Mohammed's tenure as pharmacy manager, none had a documented investigation performed to determine why the discrepancy existed.

Count 7

48. Additionally, despite requirements in several regulations and practice directions, Mr. Mohammed failed to submit reports to Health Canada and the College within 10 days of discovery of unexplained shortages of narcotics, controlled drugs, or targeted substances. Although a few of the many shortages were reported to Health Canada (but not to the College), such reports were never made within the ten-day reporting period.

49. Mr. Mohammed also kept narcotic and controlled drug inventory reports that were unclear or difficult to read or decipher. Lastly, the investigator observed several occasions during site visits where the narcotic safe was left unlocked or open, including three occasions where Mr.

Mohammed was the pharmacist on duty.

50. As pharmacy manager, Mr. Mohammed was required by the Regulation to establish, implement and maintain sufficient written policies and procedures. The purpose of these polices and procedures is to identify, mitigate and avoid situations that expose patients and staff to inappropriate risk and to ensure safe and effective pharmacy practice.

51. Mr. Mohammed has admitted that he breached his obligations in several respects, including with respect to site-specific policies and procedures for preparation and administration of OAT (Count 7(b)), for expeditiously addressing and documenting medication incidents (Count 7(c)), for securing and managing narcotic and controlled drug inventory (Count 7(d)), for assessing and using technology to ensure safe and effective pharmacy practice (Count 7(e)), for providing and documenting patient counselling (Count 7(f)), and for retaining accurate pharmacy records (Count 7(g)). In each of these areas, policies and procedures either did not exist, or were not implemented and maintained.

Count 8

52. Count 8 relates to Mr. Mohammed's failure to ensure that the Main St. Pharmacy was adequately staffed to enable safe and effective practice to meet patient health care needs, in breach of the Regulation and the Code.

53. Before Mr. Mohammed became an owner in February 2021, pharmacists were regularly scheduled to overlap for eight hours. After Mr. Mohammed became owner, the overlapping shifts were removed almost entirely, leaving the pharmacy understaffed.

54. The high volume of patients, including many that required OAT services, coupled with the lower and less experienced staffing levels and the lack of policies, created a high-pressure environment and increased the risk of errors. Pharmacists who worked at the Main St. Pharmacy after Mr. Mohammed became an Associate Owner reported that the work environment was stressful, difficult and/or exhausting because the staff was generally inexperienced and there was generally only one pharmacist on duty at a time. One of the pharmacists stated that he believed the staffing levels led to serious risks in patient safety.

Count 9

55. Count 9 relates to Mr. Mohammed's failure to maintain and produce for regulatory review certain records in breach of the Regulation, the Records PD and the OAT Guidelines.

Count 10

56. Count 10 relates to Mr. Mohammed's failure to inform patients on approximately three occasions that their personal health info1mation had been breached, in contravention of the Code and the Records PD.

May 2024 Notice

57. The May 2024 Notice relates to misconduct by Mr. Mohammed at the Morden Pharmacy.

Counts 2, 4, 5, 8 & 9

58. 58. These counts are all connected to a kidney transplant patient who did not receive anti- rejection medications for more than two months.

59. Count 2 relates to Mr. Mohammed's failure as pharmacy manager at Morden Pharmacy to implement written policies and procedures with respect to the creation of the prescription record and the final check process for new and refill prescriptions.

60. When the patient ran out of refills for one of the medications, two fax requests for a refill prescription were sent to the wrong clinic. It was not until approximately two months later, when the patient was contacted by the correct clinic to schedule a routine checkup, that the missed medication was identified, and a refill prescription was sent to the Morden Pharmacy.

61. The patient then had to undergo a series of procedures to save [redacted] kidney from rejection, including an emergency kidney biopsy and plasmapheresis.

62. The policies and procedure manual at the Morden Pharmacy contained a policy requiring that previously entered information, including the prescriber's address and contact info1mation, be verified before signing off on the "Final Check" of a new or refilled prescription. However, in practice, this was rarely or never done for refill prescriptions. In an interview with the College's investigator, one of the staff pharmacists indicated that there was not sufficient time to verify the details of all original orders.

63. In this case, the patient visited the pharmacy at least 12 times to fill and refill [redacted] transplant-related prescriptions, and none of the pharmacists who served [redacted] including Mr. Mohammed, caught the error in the prescriber's address and contact information.

64. In his capacity as pharmacist, Mr. Mohammed also failed to identify the outstanding medication authorization request and failed to follow up with the patient and the prescriber about it when he assisted the patient with another prescription.

65. As pharmacy manager, he also failed to establish, implement and maintain written policies and procedures with respect to continued care authorizations. The patient in this case should have been offered a continued care prescription by the Morden Pharmacy, but there was no guidance for pharmacists on that issue in the policy and procedure manual.

66. The patient's inability to access a supply of the anti-rejection medications [redacted] required, which potentially resulted from the Morden Pharmacy's data entry errors, misdirected faxes and/or failure to follow up on prescription refill requests meets the definition of, and should have been treated as, a medication incident. Mr. Mohammed failed to inform and apologize to the patient for the medication incident, in breach of the Incidents PD, and failed to address, document and report the medication incident to the pharmacy manager and to the national incident database, in breach of the Regulation and the Incidents PD.

Counts 6 & 7

67. Mr. Mohammed has admitted that, as pharmacy owner, he failed to implement sufficient written pharmacy policies and procedures with respect to patient counselling and that he failed to ensure that patient counselling and patient counselling refusals were documented.

68. Although the Morden Pharmacy policies and procedure manual contained guidance to the effect that counselling should be provided for all prescriptions, both new and refill, out of a relatively

narrow sample size, the investigator identified hundreds of instances where counselling was not documented. Mr. Mohammed told the investigator that he was aware that pharmacists at Morden Pharmacy were generally not compliant with instructions to ensure that patient counselling occurred. He estimated that counselling occurred about 60 to 70% of the time, but that pharmacy staff were careless about documenting it.

Counts 11 & 12

69. Counts 11 and 12 relate to a fentanyl prescription provided to [redacted], a patient of the Morden Pharmacy. The details of this incident are described in more detail in the discussion on sentence below. In summary, [redacted] was prescribed fentanyl lollipops, a form of fentanyl Mr. Mohammed was not familiar with. Instead of dispensing the prescribed lollipops, Mr. Mohammed dispensed fentanyl patches with a label that contained erroneous wording. Mr. Mohammed's mistaken substitution of patches for lollipops resulted in the patient receiving considerably more fentanyl than [redacted] had been prescribed.

70. With respect to Count 11, Mr. Mohammed has admitted that he failed to review "[redacted]'s" fentanyl prescription and failed to ensure that the drug provided was appropriate, was the correct dose, was the correct route of administration, was the correct dosage form, was not a therapeutic duplication, and was provided consistent with the standards of care and patient safety.

71. With respect to Count 12, Mr. Mohammed has admitted that he failed to consult with the prescriber about several aspects of the fentanyl prescription. This conduct contravened various provisions of the Regulation, the Patient Safety Practice Direction and the Code, as outlined in the count.

Counts 13, 14, 15, 16 & 17

72. These counts relate to Mr. Mohammed's failures, as pharmacy manager and/or pharmacy owner of Morden Pharmacy, to perform proper and accurate controlled substance inventory counts when required, to ensure that investigations of discrepancies in the perpetual inventory were conducted and documented, and to ensure that all unexplained shortages were reported to both the Health Canada and to the College. In the Statement, Mr. Mohammed admits that there were dozens of discrepancies that went uninvestigated or for which investigations were not documented and that there were dozens of shortages that were not reported in a period of approximately two and a half years. This misconduct is similar to the misconduct identified in connection with the Main St. Pharmacy and described in Count 6 of the Amended August 2023 Notice.

B. Partial Joint Recommendation

73. A disciplinary panel should not depart from a joint recommendation unless it is of the view that the joint recommendation would bring the administration of justice into disrepute or is otherwise contrary to the public interest.

74. In this case, the Panel accepts that the partial joint recommendation meets the objectives of sentencing with respect to those aspects of sentence that it addresses.

75. The Panel agrees that a serious fine is appropriate, given the seriousness and breadth of the Charges. Moreover, since many of the Charges stem from Mr. Mohammed's conduct as pharmacy manager, it is appropriate, in the interest of protecting the public, to restrict Mr. Mohammed from being a pharmacy manager for a two-year period. The requirement to complete the College's Pharmacy Manager Training Program before relicensing as a Pharmacy Manager, which is

mandatory for all pharmacy managers anyway, is also appropriate for obvious reasons.

76. Although the Panel accepts the partial joint recommendation with respect to the aspects of sentence that it deals with, the Panel cannot accept that the partial joint recommendation provides an adequate sentence considering the seriousness, variety and volume of the misconduct to which Mr. Mohammed has pled guilty. The Panel finds that to fulfill its statutory function to protect the public, it must also impose a suspension in the circumstances of this case.

C. Suspension

77. The Complaints Committee submitted that Mr. Mohammed did not make patient safety a priority and that his misconduct was egregious, irresponsible and led to direct patient harm in several instances. It therefore submitted that a suspension of four months would be appropriate, in addition to the penalty contained in the partial joint recommendation.

78. Mr. Mohammed submitted that a suspension was not necessary because the partial joint recommendation contained an adequate penalty for Mr. Mohammed's misconduct. Although Mr. Mohammed acknowledged that his misconduct led to actual and potential patient harm, he submitted that there is nothing to suggest that his ongoing practice presents a risk to the public. Alternatively, Mr. Mohammed submitted that a suspension of two weeks to one month would be appropriate.

79. The Panel is unable to accept Mr. Mohammed's primary or alternative positions on suspension. Given the number of Charges to which Mr. Mohammed has pled guilty, the lengthy date range over which the Charges occurred, the wide variety of circumstances that gave rise to the various Charges, the variety of roles to which the Charges relate, including with respect to Mr. Mohammed's conduct as a pharmacist, a pharmacy manager, and a pharmacy owner, the seriousness of several of the Charges, and the high level of risk that occurred to the public as a result of Mr. Mohammed's misconduct, the Panel finds that a more significant suspension is required to achieve the objectives of sentencing and to serve and protect the public, as required by s. 5(2) of the Act.

80. In addition to the overriding purpose of protecting the public, the other objectives of sentencing include specific deterrence for the member, general deterrence for other members of the profession, denunciation of the misconduct, punishment of the member, potential rehabilitation of the member, and maintaining the public's confidence in the profession's ability to properly supervise the conduct of the member.

81. In determining an appropriate sentence, the Panel has been guided by these principles, as well as by the factors set out in Jaswal v. Medical Board (Nfld.), to which both parties referred in their submissions. Although the Panel has considered each of the Jaswal factors, it finds the following ones most significant in the present case.

<u>Nature and Gravity of the Proven Allegations</u>

82. The Charges arise from five complaints relating to conduct that took place over the span of more than two years at two different pharmacies. Mr. Mohammed has pled guilty to 36 separate charges and subcharges and admits to misconduct arising from his activities as a pharmacist, as a pharmacy manager, and as a pharmacy owner.

83. Mr. Mohammed has admitted that his conduct caused actual and potential patient harm. He has admitted that he carried on practice in areas for which he lacked the necessary experience and

training, including most seriously, with respect to OAT. The Panel finds the OAT-related misconduct particularly troubling, given the heightened vulnerability typical of OAT patients.

84. When Mr. Mohammed purchased the Main St. Pharmacy and became its pharmacy manager, he assumed responsibility for the policies and procedures it had in place. Given Mr. Mohammed's lack of OAT-related experience and training, he appears to have been unable to evaluate the adequacy of the policies and procedures in place at the Main St. Pharmacy. The admitted facts relating to count 4 from the Amended August 2023 Notice also demonstrate that Mr. Mohammed failed to take reasonable steps to ensure that pharmacists providing patients with OAT, notably including himself, were adequately trained, proficient and competent with respect to OAT. This should have been done immediately upon Mr. Mohammed's acquisition of the Main St. Pharmacy. Although not part of the evidence, the pharmacist members of the Panel point out that OAT-related training can be completed in Winnipeg without an onerous time-commitment.

85. This was a serious abdication of Mr. Mohammed's professional obligations, especially considering that the Main Street Pharmacy serviced many OAT patients. As a result of Mr. Mohammed's misconduct, in his role as pharmacist, pharmacy manager, and pharmacy owner, these patients were unnecessarily placed at risk of serious harm.

86. Mr. Mohammed also changed the policies at Main St. Pharmacy with respect to preparation of methadone doses for the patient population. Before the policy change, most methadone doses for the week would be prepared in advance for each patient. However, to reduce waste for patients who missed or skipped their doses, Mr. Mohammed changed the practice so that methadone doses would be prepared when a patient came into the pharmacy. Because of the high volume of OAT patients, this policy change placed the pharmacists under additional time pressure, especially if there were many patients waiting at the same time.

87. The risk of patient ha1m caused by Mr. Mohammed's misconduct is well-illustrated by the admitted facts relating to counts 1 and 2 from the Amended August 2023 Notice. The inadequacy of the policies and procedures at the Main St. Pharmacy exposed these and other patients to serious risk in several ways, including:

    a. Methadone doses were allowed to be stored and reused in an unsafe and uncompliant manner, which contributed to Mr. Mohammed's own medication errors, his failure to record the steps he took to prepare the doses he administered to patients [redacted] and [redacted], and his inability to confirm whether they had received the correct doses or were at risk of harm due to an overdose. The Panel notes that by Mr. Mohammed's best estimation, both patients received significantly increased doses of methadone because of his error.

    b. Inconect prescriber information was entered into patient files and not verified or conected, which resulted in Mr. Mohammed being unable to notify the prescribers in a timely way when the medication errors were discovered and which resulted in privacy breaches when the wrong clinics were contacted.

    c. Mr. Mohammed did not properly document and report the medication enors, which restricted his and the pharmacy's ability to learn from the incident, and to prevent similar incidents from happening in the future.

    d. Mr. Mohammed's efforts to address the medication enors were not properly documented, which restricted his, the prescribers' and the College's ability to understand the events before and after the medication enors.

88. Count 3 from the Amended August 2023 Notice is another methadone-related medication error. Mr. Mohammed admitted in the Statement that he should have, but didn't, identify that the carry dose information recorded on patient [redacted]'s prescription for methadone was incorrect. This error may have resulted in carry doses being provided to the patient that should have been witnessed doses. The Panel notes this put the patient at increased risk of an overdose.

89. The admitted facts surrounding count 5 from the Amended August 2023 Notice establish a pattern of repeated failure by Mr. Mohammed to document and report medication incidents at the Main Street Pharmacy. As acknowledged in the Statement, proper documentation is important, among other reasons, because it provides opportunities for the pharmacy and its pharmacists to identify factors that contributed to the medication incident and to take steps to identify how similar incidents can be avoided in the future. It is also critical that prescribers be notified of medication incidents, so that they can address ensuing medical effects.

90. Counts 6 and 7 from the Amended August 2023 Notice, and the admitted facts relating to these counts, similarly establish a pattern of misconduct by Mr. Mohammed, this time sunounding the failure to properly secure narcotic and controlled diug substance invento1y at Main St. Pharmacy and the failure to implement and maintain sufficient written policies and procedures at Main St. Phaimacy in a variety of important areas, including preparation and administration of OAT, and other matters closely tied to patient safety.

91. Mr. Mohammed's repeated failures to keep accurate narcotics counts at Main St. Pharmacy bear specific denunciation. The requirements to regularly confirm an accurate inventory for controlled narcotics and other controlled substances are in place to prevent fraudulent diversion of these substances and to assist in the prevention, detection and investigation of potential medication errors.

92. The Panel accepts the comments of [redacted], [redacted] and [redacted] with respect to the control that Mr. Mohammed retained over narcotic counts and other narcotic accountability practices, including investigating discrepancies and reporting shortages. The Panel finds that even after he ceased to occupy the role of pharmacy manager at Main St. Pharmacy, Mr. Mohammed continued to exert direct influence and control over how pharmacy practice was delivered at Main St. Pharmacy.

93. 93. The Panel is troubled by what appears to have been a shared culture of unsafe practice at both the Main St. Pharmacy and the Morden Pharmacy. In the Panel's view, Mr. Mohammed bears primary responsibility for this shared culture and the risk to the public it caused.

94. The risks created by the admitted facts relating to counts 6 and 7, were compounded by Mr. Mohammed's failure to ensure adequate staffing at the Main St. Pharmacy, as admitted in the section of the Statement that deals with count 8 of the Amended August 2023 Notice. Given the volume of patients, particularly those requiring OAT services, adequate staffing was critical to reduce the risk of patient harm. Unfortunately, Mr. Mohammed's failure to adequately staff the Main St. Pharmacy did the opposite. Mr. Mohammed's decision to eliminate overlapping pharmacist shifts meant that generally only one pharmacist was on duty to handle the high-demand patient population at the Main St. Pharmacy. This reduced the safety and effectiveness of the oversight of patient care. Based on the statements made by the various pharmacists interviewed by the College's investigator, the Panel finds that the Main St. Pharmacy was a chaotic, high-stress work environment, which increased the risk of medication errors and undermined patient safety.

95. The facts admitted by Mr. Mohammed in relation to the Charges in the May 2024 Notice are also

concerning to the Panel. The Panel found two of these episodes particularly alarming.

96. The first relates to patient [redacted] a kidney transplant recipient prescribed anti-rejection medications. Mr. Mohammed admits that he failed to implement written policy and procedures with respect to the creation of the prescription record and the final check process. Unfortunately for the patient, the risk created by the absence of these policies and procedures was manifested when multiple staff pharmacists, including Mr. Mohammed, failed to identify an error in the contact information for the prescribing physician. Because the prescriber's contact information was incorrect, the Morden Pharmacy's requests to refill one of the patient's anti-rejection medications were not received. Additionally, Mr. Mohammed, who served the patient on at least one occasion, failed to identify the gap in the patient's prescribed medication therapy and failed to notify the patient and the prescriber of that gap.

97. As a result of the original error, the repeated failures to detect it, and the failure to follow up with the prescriber about the outstanding or "owing" medications, the patient did not receive two different anti-rejection medications for a period of time. This necessitated a series of procedures to save the kidney from rejection.

98. When Mr. Mohammed learned of the medication enor that caused the patient to miss necessary medications, he failed to report it to the phannacy manager and the national incident database and he failed to inform, and apologize to, the patient. Each of these failures was a breach of Mr. Mohammed's obligations.

99. Additionally, as documented in the admitted facts sunounding count 5, the patient qualified for, and should have been offered, a continued care prescription for the missing antirejection medication. However, the Morden Pharmacy lacked a continued care prescription policy, something it not only should have had, but something that Mr. Mohammed told the College he had implemented in August 2018.

100. In July 2018, during a routine College inspection of the Morden Pharmacy, Mr. Mohammed, who was then the pharmacy owner and pharmacy manager, was advised that he needed to update the Morden Pharmacy's policies and procedures manual with an updated continued care prescription policy. On August 15, 2018, Mr. Mohammed replied to the College to acknowledge the deficiency regarding the continued care prescription policy and to attest that he had updated the manual as directed. In July 2023, the College's investigator found no evidence that Mr. Mohammed had updated the manual. The Panel infers that Mr. Mohammed's August 15, 2018 attestation to the College was false or misleading.

101. The second episode the Panel wishes to highlight from the May 2024 Notice relates to patient [redacted], who had a terminal illness and had been prescribed fentanyl lollipops. At the time of this prescription, Mr. Mohammed did not know that fentanyl could be supplied in a lollipop format. Instead of consulting with the prescriber, as he should have, Mr. Mohammed dispensed ten 50 mcg/hour Teva-Fentanyl patches, instead of the prescribed ten 50 mcg lollipops. This represented a rapid escalation in the patient's opioid dosage. In fact, added to the patient's existing opioid regimen, the patches resulted in an increase to the patient's morphine equivalent dose per day of 2.36 times. This put the patient at serious risk of harm or overdose.

102. Mr. Mohammed has admitted that the rapid escalation in the patient's opioid dose should have prompted him to intervene with the prescriber on behalf of the patient, which he did not do. The patient, or [redacted] agent, picked up the fentanyl patches and used them for a few days until the medication enor was discovered and reported to the prescriber. When the patient advised

[redacted]prescriber that [redacted]"liked" the patches, the prescriber agreed to prescribe fentanyl patches at the lower dose of 25 mcg/hour. This lower dose could not be implemented because the patient passed away before[redacted]could fill the new prescription. To be clear, the Panel was presented with no evidence that the patient's death was related to Mr. Mohammed's medication enor and makes no finding in that respect.

103. Nevertheless, the Panel is deeply troubled by Mr. Mohammed's carelessness as it related to this patient, this prescription, and this substance, which is highly dangerous if misused.

104. The Panel notes that several of the other counts in the May 2024 Notice fit within the patterns identified above in connection with the Amended August 2023 Notice. These include failure to implement sufficient policies and procedures in a variety of areas (counts 2, 5 and 6), failure to ensure that patient counselling and patient counselling refusals were properly documented (count 7), failure to comply with narcotic and controlled drng accountability guidelines (counts 13), failure to keep accurate controlled substance counts (count 14), and failure to investigate, document and report inventory count discrepancies and unexplained shortages (counts 15, 16 and 17).

105. On their own, the admitted facts relating to each count to which Mr. Mohammed has pled guilty would be concerning from a public safety perspective. Taken together, the seriousness, volume and variety of Mr. Mohammed's misconduct weigh heavily in favour of a serious suspension.

Age and Experience of Mr. Mohammed

106. Mr. Mohammed was not an inexperienced pharmacist during the period relevant to the various instances of misconduct. He has been a practicing pharmacist since 1999. He has been registered to practice pharmacy in Manitoba since 2010. He has been a pharmacy owner since 2011. He was a pharmacy manager for approximately ten years before the events relating to the Charges occurred.

Previous Character and Discipline History

107. In reaching its decision on sentence, including with respect to suspension, the Panel has considered that Mr. Mohammed has no prior discipline history. The Panel received submissions from the parties as to whether the absence of previous discipline is a mitigating factor or a neutral factor for the purposes of sentencing. This factor was not decisive to the outcome and the Panel therefore does not find it needs to decide the issue on the facts of this case. For the purpose of the present case, the Panel has treated the lack of discipline history as a mitigating factor.

108. The Panel has also reviewed and considered the affidavit of [redacted], which contained letters from several of Mr. Mohammed's colleagues and employees, among others, discussing Mr. Mohammed's character. The Charges do not directly relate to matters of character, and the Panel therefore does not find that this evidence is of assistance in determining whether a suspension should be imposed.

Acknowledgement of Misconduct

109. Mr. Mohammed has pled guilty to the Charges, has admitted the seriousness of his misconduct, has accepted accountability for his misconduct, and has saved the time and expense of a contested hearing, which would have been considerable in this case.

Mitigating Circumstances

110. The Panel accepts that Mr. Mohammed's unexpected medical leave in May and June 2021, was a mitigating factor with respect to those Charges arising in or around that period. The Panel does not consider the medical leave to be a mitigating circumstance for Charges arising out of conduct from different periods of time.

111. The Panel also recognizes that the Covid pandemic presented significant and unexpected challenges for Mr. Mohammed and the Morden and Main St. Pharmacies, as it did for most, if not all, pharmacists and pharmacies. However, the Panel also notes that Mr. Mohammed consciously decided to purchase the Main St. Pharmacy during the Covid pandemic. Moreover, any challenges caused by the pandemic would have been mitigated had Mr. Mohammed taken steps to ensure that the practices and procedures at the two pharmacies were adequate. His failure to do so appears to have exacerbated the chaos the pandemic caused at the Morden and Main St. Pharmacies.

Specific and General Deterrence

112. The factors of specific and general deterrence weigh heavily in favour of a serious suspension for Mr. Mohammed. The Panel agrees with the Complaints Committee's submission that Mr. Mohammed needs to be deterred from engaging in similar conduct in the future. A pharmacist practicing in an area for which he lacks adequate training, expertise and experience is a danger to the public. In this case, not only was Mr. Mohammed practicing without adequate training expertise and experience, but he was responsible for the policies and procedures for two pharmacies as either or both pharmacy manager and pharmacy owner. The lack of adequate policies and procedures at both pharmacies resulted in actual and possible harm to patients. This harm resulted from data entry and verification errors, failure to recognize medication errors, failure to report medication errors and issues to prescribers, failure to provide proper doses to patients, privacy breaches, and failure to offer and provide counselling to patients, among other things.

113. The breadth and seriousness of misconduct in this case requires a serious sanction so that Mr. Mohammed will be deterred from similar conduct in the future. The Panel notes that even while the investigations were proceeding, Mr. Mohammed and the two pharmacies continued to fall short with respect to practice matters and policies and procedures.

114. Similarly, the Panel finds that a serious sanction is needed to properly denounce this misconduct and to deter other members of the profession from engaging in similar misconduct in the future.

Maintenance of Public Confidence and Degree to Which Misconduct Fell Outside Permitted Conduct

115. These two factors also militate for a serious sentence. The misconduct fell well outside the range of permitted conduct. A serious sentence is required to maintain public confidence in the integrity of the profession and its ability to self-regulate.

Sentences in Similar Cases

116. The Panel has reviewed and considered each of the cases submitted by the Complaints Committee and by Mr. Mohammed. For the most part, the cases cited by Mr. Mohammed involved fewer guilty findings and less serious misconduct.

117. The Panel is of the view that a four-month suspension is on the lower end of the range of the suspensions imposed in the cases most factually similar to the present one.

Conclusion on Sentence

118. The Panel therefore concludes that a penalty combining a four-month suspension, with the other aspects of penalty contained in the partial joint recommendation is proportionate to the misconduct and meets the objectives of sentencing.

D. Costs

119. Under s. 56(1) and (2) of the Act the Panel has broad discretion with respect to an order for costs. Section 56(1) of the Act permits the Panel to order all or part of the costs of the investigation and hearing. Section 56(2) of the Act expressly provides that costs include, among other things, the fees and expenses of investigators, payments made to members of the Panel, and costs incurred for the engagement of counsel for both the Complaints Committee and for the Panel.

120. The Panel accepts the submission, made by both parties, that an order for costs is not intended to be punitive. Instead, such an award is intended to distribute costs between the general membership of the College and the member whose misconduct has necessitated the investigation and hearing. The Panel also recognizes that costs should not be so prohibitive that they prevent members from defending themselves against professional discipline charges.

121. The Complaints Committee submitted that Mr. Mohammed should contribute to the College's costs in the amount of $35,000. This represents approximately 20% of the total costs incurred and estimated by the College up to the date of the hearing.

122. In quantifying the College's costs, the Complaints Committee submitted an affidavit from Dr. Brent Booker, the College's Assistant Registrar for Review and Resolution. Dr. Booker deposed that prior to the hearing, the College had incurred $124,742.18 with respect to the costs of the investigator and legal counsel for the Complaints Committee prior to December 2025. Dr. Booker estimated that legal fees for the Complaints Committee in December 2025 and January 2026 would be at least an additional $45,000. These actual and estimated costs did not include the payments to the members of the panel, the costs of counsel to the Panel, or the costs of the court reporter at the hearing.

123. Mr. Mohammed submitted that a more appropriate costs award would fall in the range of $10,000 to $15,000. He submitted that the Complaints Committee had not filed sufficiently detailed evidence to enable the Panel to properly evaluate its request for costs. He also submitted that because other pharmacists were subjects of the investigations, Mr. Mohammed should not be required to bear the full cost associated with those investigations. In this regard, he pointed out that $18,500 in costs has already been awarded against other pharmacists associated with these investigations.

124. Mr. Mohammed also made extensive submissions based on the case Charkhandeh v. College of Dental Surgeons of Alberta, a recent decision from the Alberta Court of Appeal that dealt with the issue of costs in professional disciplinary matters in Alberta.

125. The Panel is not persuaded that Charkhandeh reflects the law in Manitoba as it relates to the statutory discretion of the Panel to order costs within the authority expressly granted by the Act.

126. With that said, the Panel agrees with Mr. Mohammed's submission that a costs award should not be an unduly onerous or crushing financial burden on the professional. However, in the Panel's view, the evidence falls short of establishing that a costs order of $35,000 –instead of $15,000 as

suggested by Mr. Mohammed – would be unduly onerous or crushing for Mr. Mohammed. This is especially so since Mr. Mohammed will have five years to pay the ordered costs.

127. The Panel accepts that there may be cases in which more detailed evidence from the Complaints Committee might be useful or necessary to determine an appropriate costs order. For instance, were the Complaints Committee to request an order that a member bear all or substantially all the College's costs, fairness might require more detail about costs incurred for investigators or legal counsel so that the reasonableness of the College's expenditures could be evaluated. Additionally, in such cases, an estimate of costs might not be sufficient.

128. In this case, however, the Panel has no difficulty accepting that the complexity and volume of the complaints and investigations reasonably required the College to spend well over $125,000 to bring the matter to a hearing. Dr. Booker's estimate of at least an additional $45,000 in costs for December 2025 and January 2026 does not strike the Panel as unreasonable.

129. Although there were other pharmacists involved in some aspects of some of the complaints, Mr. Mohammed was, in the view of the Panel, the central figure in the investigations. There is no danger of the College being overcompensated as a result of the costs orders made to the other pharmacists, each of which was made as part of a joint recommendation. As a result, the Panel finds that the other costs orders are of limited relevance to the determination of a reasonable costs order in this case.

130. The Panel finds that $35,000 is a reasonable, proportionate and fair contribution to the College's costs.

131. To summarize, pursuant to ss. 55 and 56 of the Act, the Panel orders that:

f. Mr. Mohammed is to be suspended for four months, which suspension is to begin within 30 days of the date of this decision;

g. Mr. Mohammed is to pay a fine of $22,000.00;

h. after completion of the suspension, Mr. Mohammed is to have a restriction on his pharmacist licence that will prohibit him from becoming a pharmacy manager or preceptor for a period of two years;

i. prior to becoming a pharmacy manager in the future, Mr. Mohammed is to be required to complete the College's Pharmacy Manager Training Program; and

j. there will be publication of the conviction, penalty and circumstances of the offences, including publication of Mr. Mohammed's name.

132. Mr. Mohammed is ordered to pay a contribution toward the costs of the investigations and hearing in the amount of $35,000.00.

133. Mr. Mohammed will have five years from the date of this decision to pay the fine and contribution to costs.

DATED at Winnipeg, Manitoba, this 12th day of April, 2026.

THE COLLEGE OF PHARMACISTS OF MANITOBA

Per:
Martha Mikulak
Chair, Discipline Panel

Erratum dated April 20, 2026

Please note that at paragraph 47 of the Decision, the number “191” has been deleted and replaced with the number “150”.