BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse License Number 698331	§	AGREED
issued to DAVID MIR NATEGHI	§	ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Board, produced evidence indicating that DAVID MIR NATEGHI, hereinafter referred to as Respondent, Registered Nurse License Number 698331, may have violated Section 301.452(b)(9),(10)&(13), Texas Occupations Code.

An informal conference was held on October 23, 2007, at the office of the Texas Board of Nursing, in accordance with Section 301.464 of the Texas Occupations Code.

Respondent appeared in person. Respondent was represented by Louis Leichter, Attorney at Law. In attendance were Mary Beth Thomas, Ph.D, MSN, RN, Executive Director's Designee; James W. Johnston, General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; and Earl E. Stearns, Senior Investigator.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license.

2. Respondent waived notice and hearing, and consented to the entry of this Order.

3. Respondent is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from North Harris/Montgomery Community College District, Houston, Texas, on May 9, 2003. Respondent was licensed to practice professional nursing in the State of Texas on July 15, 2003.

5. Respondent's professional nursing employment history includes:

07/03 - 05/06 ER Nurse Memorial Hermann - The Woodlands Hospital
The Woodlands, Texas

06/06 - Present Not Employed in Nursing

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with Memorial Hermann - The Woodlands Hospital, The Woodlands, Texas, and had been in this position for approximately two (2) years and ten (10) months.

7. On or about May 2, 2006 through May 24, 2006, while employed as a Registered Nurse with Memorial Hermann - The Woodlands Hospital, The Woodlands, Texas, Respondent withdrew Dilaudid (Hydromorphone), Demerol (Meperidine), and Ativan (Lorazepam) from the Medication Dispensing System (Pyxis) for patients, without valid physicians' orders, as follows:

Date	Patient	Physician's Order	Medication Dispensing System (Pyxis)	ED Treatment Orders and ED Notes	Wastage
05-02-06	350561376122	None	Hydromorphone 2mg/1ml vial 1047 Qty: 1	Dilaudid Respondent withdrew was not documented as administered, but instead, documented as wasted.	2mg @ 1323 (Witnessed)
05-03-06	332349156123	None	Hydromorphone 2mg/1ml vial 1025 Qty: 1	Toradol & Valium were ordered for pt. Dilaudid Respondent withdrew was not documented as administered, but instead, documented as wasted.	2mg @ 1412 (Witnessed)
05-04-06	471144466124	None	Meperidine 50mg/1ml vial 1907 Qty: 1	Demerol Respondent withdrew was not documented as administered.	None Documented
05-08-06	374675796128	None	Hydromorphone 2mg/1ml vial 1929 Qty: 1	Dilaudid Respondent withdrew was not documented as administered.	None Documented
05-09-06	377751636129	None	Hydromorphone 2mg/1ml vial 0945 Qty: 1	Pt had already been administered Dilaudid 1mg IVP at 0943 by RN Amanda Forsythe. Dilaudid Respondent withdrew was not documented as administered, but instead, documented as wasted.	2mg @ 1011 (Witnessed)
05-09-06	342464776129	None	Hydromorphone 2mg/1ml vial 1351 Qty: 1	Respondent documented that he administered Dilaudid 1mg IVP at 1349.	2mg @ 1532 (Witnessed)

Date	Patient	Physician's Order	Medication Dispensing System (Pyxis)	ED Treatment Orders and ED Notes	Wastage
05-11-06	379639156131	None	Hydromorphone 2mg/1ml vial 1306 Qty: 1	Dilaudid Respondent withdrew was not documented as administered, but instead, documented as wasted.	2mg @ 1506 (Witnessed)
05-11-06	358955876129	None	Lorazepam 2mg/1ml vial 1148 Qty: 1	Lorazepam Respondent withdrew was not documented as administered.	None Documented
05-11-06	361073676131	None	Hydromorphone 2mg/1ml vial 1723 Qty: 1	Dilaudid Respondent withdrew was not documented as administered, but instead, documented as wasted. RN Ann Hejtmancik reported that pt. verbalized no complaints between 1715 and 1830	2mg @ 1730 Witnessed
05-16-06	378472996136	None	Hydromorphone 2mg/1ml vial 1207 Qty: 1	RN Cortney Smith documented Dilaudid 1mg given IVP at 1047. Dilaudid Respondent withdrew was not documented as administered, but instead, documented as wasted.	2mg @ 1359 (Witnessed)
05-16-06	359741506136	None	Hydromorphone 2mg/1ml vial 1744 Qty: 1	Respondent documented Morphine 4mg given IVP at 1750. Dilaudid Respondent withdrew was not documented as administered, but instead, documented as wasted.	2mg @ 1804 (Witnessed)
05-17-06	379458796137	None	Hydromorphone 2mg/1ml vial 1814 Qty: 1	Dilaudid Respondent withdrew was not documented as administered, but instead documented as wasted.	2mg @ 1834 (Witnessed)
05-24-06	379719466144	None	Hydromorphone 2mg/1ml vial 0940 Qty: 1	Dilaudid Respondent withdrew was not documented as administered, but instead, documented as wasted.	2mg @ 0947 (Witnessed)

Respondent's conduct was likely to injure the patient, in that the administration of Dilaudid, Demerol and Ativan without a valid physician's order could result in the patient experiencing respiratory depression and was in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).

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8. On or about May 4, 2006 through May 11, 2006, while employed as a Registered Nurse with Memorial Hermann - The Woodlands Hospital, The Woodlands, Texas, Respondent withdrew Demerol (Meperidine), Dilaudid (Hydromorphone), and Ativan (Lorazepam) from the Medication Dispensing System (Pyxis) for patients, but failed to document, or accurately document the administration of the medications in the patients' Emergency Department Treatment Orders and/or Emergency Department Notes, as follows:

Date	Patient	Physician's Order	Medication Dispensing System (Pyxis) Time and Amount	ED Treatment Orders	ED Notes	Wastage
05-04-06	471144466124	None	Meperidine 50mg/1ml vial 1907 Qty: 1	Not Documented (See Note 1)	Not Documented (See Note 1)	None Documented
05-08-06	374675796128	None (See Note 2)	Hydromorphone 2mg/1ml vial 1929 Qty: 1	Not Documented	Not Documented	None Documented
05-11-06	358955876129	None	Lorazepam 2mg/1ml vial 1148 Qty: 1	Not Documented	Not Documented (See Note 3)	None Documented

Note 1: Respondent administered Demerol 75mg at 1521 and Demerol 50mg at 1757, as ordered. RN Rebecca Schoeneman became patient's primary nurse at 1851. There was no order for the Demerol Respondent withdrew at 1907.

Note 2: Dilaudid 1-2mg IV x 1 was ordered at 1245 and Dilaudid 1mg IV x 1 may repeat x 1 was ordered at 2130. The Dilaudid was administered as ordered by RN's John Conyers, Devonne Bouffiou and Karolyn Swann. There was no order for Dilaudid Respondent withdrew at 1929.

Note 3: ED Notes state that there were no medications given to the patient.

Respondent's conduct was likely to injure the patients in that subsequent care givers would rely on his documentation to further medicate the patients which could result in an overdose and placed the hospital in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substance Act).

9. On or about May 3, 2006 through May 16, 2006, while employed as a Registered Nurse with Memorial Hermann - The Woodlands Hospital, The Woodlands, Texas, Respondent withdrew Valium (Diazepam), Dilaudid (Hydromorphone), Demerol (Meperidine), and Ativan (Lorazepam) from the Medication Dispensing System (Pyxis) for patients, but failed to follow the facility's policy and procedure regarding wastage of any of the unused portions of the medications, as follows:

Date	Patient	Physician's Order	Medication Dispensing System (Pyxis) Time and Amount	ED Treatment Orders and ED Notes	Wastage
05-03-06	332349156123	Valium 5mg IM	Diazepam 10mg/2ml INJ 1225 Qty: 1	1242 Valium 5mg IM Left Upper Quter Gluteus	None Documented

Date	Patient	Physician's Order	Medication Dispensing System (Pyxis) Time and Amount	ED Treatment Orders and ED Notes	Wastage
05-03-06	379593756123	Dilaudid 3mg INJ	Hydromorphone 4mg/1ml INJ 1426 Qty: 1	1436 Dilaudid 1mg intravenous push	None Documented
05-04-06	471144466124	None	Meperidine 50mg/1ml vial 1907 Qty: 1	Not Documented	None Documented
05-06-06	379614216126	Dilaudid 1mg IV	Hydromorphone 4mg/1ml INJ 1120 Qty: 1	1142 Dilaudid 1mg intravenous push	None Documented
05-08-06	374675796128	None	Hydromorphone 2mg/1ml vial 1929 Qty: 1	Not Documented	None Documented
05-11-06	358955876129	None	Lorazepam 2mg/1ml vial 1148 Qty: 1	Not Documented	None Documented
05-16-06	379669506136	Dilaudid 1mg IV	Hydromorphone 2mg/1ml vial 0901 Qty: 1	0855 Dilaudid 1mg intravenous push	None Documented

Respondent's conduct was likely to deceive the hospital pharmacy and placed them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substance Act).

10. On or about May 24, 2006, while employed as a Registered Nurse with Memorial Hermann - The Woodlands Hospital, The Woodlands, Texas, Respondent engaged in the intemperate use of Opiates, in that Respondent produced a specimen for a drug screen which resulted positive for Hydrocodone (10,909 ng/ml) and Hydromorphone (22,977 ng/ml). Possession of Hydrocodone and/or Hydromorphone without a lawful prescription is prohibited by Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act). The use of Hydrocodone and/or Hydromorphone by a Registered Nurse, while subject to call or duty, could impair the nurse's ability to recognize subtle signs, symptoms or changes in the patient's condition, and could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.

11. On or about May 2, 2006 through May 24, 2006, while employed as a Registered Nurse with Memorial Hermann - The Woodlands Hospital, The Woodlands, Texas, Respondent misappropriated Dilaudid from the facility and patients thereof, in that Respondent admitted that he misappropriated the Dilaudid for his own personal use. Respondent's conduct was likely to defraud the facility and patients thereof of the cost of the medications.

12. In response to Findings of Fact Numbers Seven (7), Eight (8), Nine (9), Ten (10) and Eleven (11), Respondent states he withdrew Dilaudid from the medication dispensing system (Pyxis) for patients without valid physicians' orders; he withdrew Dilaudid from the Pyxis and failed to follow the hospital's policy and procedure for wastage of any of the unused portions of the medication; he misappropriated Dilaudid from The Woodlands Hospital for his own personal use; and his use of Dilaudid contributed to the positive drug screen. Respondent states there were no other drugs involved (Valium, Demerol and Ativan), as alleged, and he would never misappropriate any medication designated for a patient. He also states that his actions represent a clear violation of the Nurse Practice Act of the State of Texas for which he accepts full responsibility.

Respondent explained that several years ago, he was diagnosed with bulging L4 and L5 discs which had been successfully treated with anti-inflammatory medications until re-aggravating the injury in late April 2006. Following this, the back pain that he experienced was so intense at times, he elected to find relief by intramuscular injections of Dilaudid. He did this three or four times during this time period. Since that time, he has contacted his primary care physician and advised him of the events that occurred so as to obtain appropriate treatment. His physician increased the dosage/frequency of his anti-inflammatory prescription, which with rest, along with heat/cold compresses completely resolved this issue.

Respondent further explained that the TPAPN was made available to him; however, upon completion of a chemical dependency evaluation by a licensed counselor, along with a SASSI evaluation, he was informed that he was ineligible for the program.

Respondent states he wholeheartedly regrets his actions in this matter, as it has caused immeasurable emotional and financial burdens on himself and his family, and needless to say, this will never occur again.

13. On October 23, 2007, Respondent presented the staff at the Texas Board of Nursing a letter, dated October 9, 2007, prepared by Gene Forrester, M.D., North Houston Nephrology & Diagnostic Associates, P.A., Houston, Texas, wherein Dr. Forrester writes: Mr. David Nateghi has been under my care for the past six years for numerous medical issues. During this time, Mr. Nateghi has had ongoing back pain issues (vertebral compression deformities and degenerative spurring) for which I have prescribed him Ultram and he has also taken NSAID medications (e.g. Lodine). A review of my office records indicates that I have not prescribed Mr. Nateghi any narcotic medications or any type of muscle relaxants. Additionally, Mr. Nateghi has not asked me to prescribe him any such medications for his chronic back pain.

    Additionally, Respondent presented the staff a SASSI-3 Substance Abuse Subtle Screening Inventory for Test Date June 20, 2006, which indicates that Respondent has a low probability of having a Substance Dependence Disorder.

14. Formal Charges were filed on September 14, 2007.

15. Formal Charges were mailed to Respondent on September 17, 2007.

16. The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or chemical dependency.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.455, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violations of Section 301.452(b)(9),(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(C),(D)&(T) and 22 TEX. ADMIN. CODE §217.12(1)(B)&(E),(4),(5),(6)(G)&(10)(A),(B),(C),(D)&(E).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 698331, heretofore issued to DAVID MIR NATEGHI, including revocation of Respondent's license to practice professional nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a REPRIMAND WITH STIPULATIONS, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas as amended, Texas Occupations Code §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE § 211.01 *et seq.* and this Order.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate licensure privilege, if any, to practice professional nursing in compact states.

IT IS FURTHER AGREED and ORDERED that while Respondent's license is encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a multistate licensure privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL deliver the wallet-sized license issued to DAVID MIR NATEGHI, to the office of the Texas Board of Nursing within ten (10) days of the date of this Order. for appropriate notation.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) contact hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding Sexual Misconduct, Fraud, Theft and Deception, Nurses with Chemical Dependency, and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/about/stipscourses.html.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6)

hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/about/stipscourses.html.*

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING A MINIMUM OF THIRTY-TWO (32) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEAR(S) OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD.

(4) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT

SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(5) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(6) For the first year of employment as a Registered Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse. Direct supervision requires another professional nurse to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(7) For the remainder of the stipulation period, RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined

unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(8) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT's capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) months for two (2) years of employment as a nurse.

(9) RESPONDENT SHALL abstain from the consumption of alcohol, Nubain, Stadol, Dalgan, Ultram, or other synthetic opiates, and/or the use of controlled substances, except as prescribed by a licensed practitioner for a legitimate purpose. If prescribed, RESPONDENT SHALL CAUSE the licensed practitioner to submit a written report identifying the medication, dosage and the date the medication was prescribed. The report shall be submitted directly to the office of the Board by the prescribing practitioner, within ten (10) days of the date of the prescription. **In the event that prescriptions for controlled substances are required for periods of two (2) weeks or longer, the Board may require and RESPONDENT SHALL submit to an evaluation by a Board approved physician specializing in Pain Management or Psychiatry. The performing evaluator will submit a written report to the Board's office, including results of the evaluation, clinical indications for the prescriptions, and recommendations for on-going treatment within thirty (30) days from the Board's request.**

(10) RESPONDENT SHALL submit to random periodic screens for controlled substances, tramadol hydrochloride (Ultram), and alcohol. For the first three (3) month period, random screens shall be performed at least once per week. For the next three (3) month period,

random screens shall be performed at least twice per month. For the next six (6) month period, random screens shall be performed at least once per month. For the remainder of the stipulation period, random screens shall be performed at least once every three (3) months.

Specimens shall be screened for at least the following substances:

Amphetamines	Meperidine
Barbiturates	Methadone
Benzodiazepines	Methaqualone
Cannabinoids	Opiates
Cocaine	Phencyclidine
Ethanol	Propoxyphene
tramadol hydrochloride (Ultram)	

A Board representative may appear at the RESPONDENT's place of employment at any time during the stipulation period and require RESPONDENT to produce a specimen for screening.

All screens shall be properly monitored and produced in accordance with the Board's policy on Random Drug Testing. A complete chain of custody shall be maintained for each specimen obtained and analyzed. RESPONDENT SHALL be responsible for the costs of all random drug screening during the stipulation period.

Any positive result for which the nurse does not have a valid prescription will be regarded as non-compliance with the terms of this Order and may subject the nurse to further disciplinary action by this Board. Failure to report for a drug screen may be considered the same as a positive result and may result in further disciplinary action by this Board.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, RESPONDENT SHALL be issued an unencumbered license and multistate licensure privileges, if any, to practice professional nursing in the State of Texas.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice professional nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 7th day of DECEMBER, 2007.

DAVID MIR NATEGHI, Respondent

Sworn to and subscribed before me this 7 day of December, 2007.

SEAL
BRANDY SCHMIDT
Notary Public, State of Texas
My Commission Expires
FEBRUARY 05, 2008

Brandy Schmidt

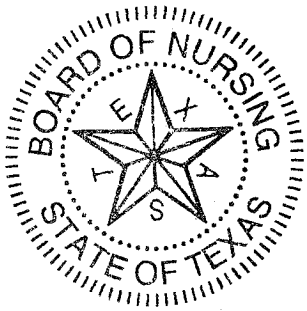
Notary Public in and for the State of Texas

Approved as to form ~~and substance~~.

LOUIS LEICHTER, Attorney for Respondent

Signed this 10 day of December, 2007

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 7th day of December, 2007, by DAVID MIR NATEGHI, Registered Nurse License Number 698331, and said Order is final.

Effective this 17th day of January, 2008.

Katherine A. Thomas, MN, RN
Executive Director on behalf
of said Board