NRC FORM 591M PART 1
(10-2003)
10 CFR 2.201

U.S. NUCLEAR REGULATORY COMMISSION

SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE/LOCATION INSPECTED:	2. NRC/REGIONAL OFFICE
St. Catherine Hospital, Inc. 4321 Fox Street REPORT East Chicago, IN 2005-02	**U.S. Nuclear Regulatory Commission** **Region III** **2443 Warrenville Road** **Suite 210** **Lisle, Illinois 60532-4351**

3. DOCKET NUMBER(S)	4. LICENSEE NUMBER(S)	5. DATE(S) OF INSPECTION
030-01590	13-01143-01	Feb. 11, 2005

LICENSEE:

The inspection was an examination of the activities conducted under your license as they relate to radiation safety and to compliance with the Nuclear Regulatory Commission (NRC) rules and regulations and the conditions of your license. The inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observations by the inspector. The inspection findings are as follows:

☒ 1. Based on the inspection findings, no violations were identified.

☐ 2. Previous violation(s) closed.

☐ 3. The violation(s), specifically described to you by the inspector as non-cited violations, are not being cited because they were self-identified, non-repetitive, and corrective action was or is being taken, and the remaining criteria in the NRC Enforcement Policy, NUREG-1600, to exercise discretion, were satisfied.

_____ Non-Cited Violation(s) was/were discussed involving the following requirement(s) and Corrective Action(s):

☐ 4. During this inspection certain of your activities, as described below and/or attached, were in violation of NRC requirements and are being cited. This form is a NOTICE OF VIOLATION, which may be subject to posting in accordance with 10 CFR 19.11.

(Violations and Corrective Actions)

Licensee's Statement of Corrective Actions for Item 4, above.

I hereby state that, within 30 days, the actions described by me to the inspector will be taken to correct the violations identified. This statement of corrective actions is made in accordance with the requirements of 10 CFR 2.201 (corrective steps already taken, corrective steps which will be taken, date when full compliance will be achieved). I understand that no further written response to NRC will be required, unless specifically requested.

Title	Printed Name	Signature	Date
LICENSEE'S REPRESENTATIVE			
NRC INSPECTOR	Deborah A. Piskura	DAPiskura	2/11/05

NRC FORM 591M PART 3
(10-2003)
10 CFR 2.201

U.S. NUCLEAR REGULATORY COMMISSION

Docket File Information

SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE	2. NRC/REGIONAL OFFICE
St. Catherine Hospital, Inc. REPORT NUMBER(S) 2008-001	**Region III** **2443 Warrenville Road** **Lisle, IL 60532**

3. DOCKET NUMBER(S)	4. LICENSE NUMBER(S)	5. DATE(S) OF INSPECTION
030-01590	13-01148-01	Feb. 11, 2008

6. INSPECTION PROCEDURES	7. INSPECTION FOCUS AREAS
87130, 87131 and 87132	03.01, 03.02, 03.03, 03.04, 03.05, 03.06, 03.07, and 03.08

SUPPLEMENTAL INSPECTION INFORMATION

1. PROGRAM CODE(S)	2. PRIORITY	3. LICENSEE CONTACT	4. TELEPHONE NUMBER
02120	G 3	Eric Zickgraf, Ph.D., RSO	219.836.7368

[X] Main Office Inspection — Next Inspection Date: Feb. 2011

[ ] Field _____

[ ] Temporary Job Site _____

PROGRAM SCOPE

This large hospital was authorized to use materials permitted in Sections 35.100, 35.200, 35.300, and 35.400. The nuclear medicine department was staffed with 4 technologists who performed approximately 200-250 diagnostic nuclear medicine procedures per month which included a full spectrum of diagnostic imaging studies. The licensee received unit doses from a licensed nuclear pharmacy. Typically in a year, the department administered 10 treatments for hyperthyroidism. Whole body CA follow up studies were administered by the license's nuclear medicine department. Radioiodine was obtained from a licensed nuclear pharmacy in capsule form. All thyroid carcinoma cases were referred to a sister hospital for treatment.

The radiation therapy department was staffed with 1 medical physicist. The hospital maintained an inventory of Cs-137 "tube" sources in secure storage. The hospital had not used its Cs-137 sources for temporary implants since the previous inspection (last case Feb. 2004). The inspector discussed disposal/transfer options of these Cs-137 sources with licensee management since the licensee expressed it would not likely resume use of these sources.

This inspection consisted of interviews with licensee personnel, a review of select records, tours of nuclear medicine radiation oncology departments, and independent measurements. The inspector observed the administration of several diagnostic nuclear medicine procedures. The inspection included observations of dose calibrator QA checks, security of byproduct material, use of personnel monitoring, and package receipts and surveys. The inspector also observed the RSO/medical physicist perform a physical inventory of the licensee's brachytherapy sources.