

SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE/LOCATION INSPECTED: Poplar Bluff Regional Medical Center d/b/a Three Rivers Health Care, North 2620 North Westwood Boulevard, Poplar Bluff, Missouri 63901 REPORT NUMBER(S) 2008-001	2. NRC/REGIONAL OFFICE U.S. Nuclear Regulatory Commission Region III 2443 Warrenville Road Suite 210 Lisle, Illinois 60532-4351
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3. DOCKET NUMBER(S) 030-11417	4. LICENSEE NUMBER(S) 24-16652-01	5. DATE(S) OF INSPECTION June 11, 2008
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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.

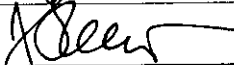

_____ Non-Cited Violation(s) was/were discussed involving the following requirement(s) and Corrective Action(s):

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)

NRC License No. 24-16652-01, License Condition No. 15, requires, in part, that the licensee conduct its program with the statements, representations and procedures contained in the application dated September 25, 2001. Item 10.4 of that application states that the licensee will establish and implement the model safety rules published in Appendix I to Reg. Guide 10.8, Revision 2, with modifications, as attached. Item 12 of the attached procedure requires, in part, that the licensee survey injection areas daily for contamination, using a radiation detection survey meter. Contrary to the above, the licensee failed to not perform daily contamination surveys of injection areas at 2352 Katy Ln, from approximately May 14, 2008, to present. As corrective action, the licensee will supply a survey instrument to that facility to use until the meter is returned from calibration.

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	Jon Scott, Associate Administ.		6/10/08
NRC INSPECTOR	Geoffrey M. Warren		6/11/08

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6. INSPECTION PROCEDURES USED 87131, 87132		7. INSPECTION FOCUS AREAS 03.01 - 03.08; 03.01 - 03.08	

SUPPLEMENTAL INSPECTION INFORMATION

1. PROGRAM CODE(S) 02120	2. PRIORITY 3	3. LICENSEE CONTACT Jim Smith, M.S., RSO	4. TELEPHONE NUMBER 573-686-5300
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<input checked="" type="checkbox"/> Main Office Inspection	Next Inspection Date: June 2011
<input checked="" type="checkbox"/> Field Office 2352 Katy Ln., Poplar Bluff, MO	
<input type="checkbox"/> Temporary Job Site Inspection	

PROGRAM SCOPE

The licensee was a 210-bed hospital located in Poplar Bluff, Missouri, which served the local city and surrounding counties. The licensee was authorized to perform activities under Sections 35.100, 35.200, 35.300, 35.400, and 35.500, but did not perform any activities under 35.500. According to the Radiology Manager, no licensed activities were performed at the South Campus on Pine Boulevard.

The nuclear medicine department was staffed with two full-time technologists. The staff typically administered 200 diagnostic doses monthly in the nuclear medicine area. Doses were primarily technetium-99m (Tc-99m) for cardiac, bone, and other studies. Tc-99m doses were received as unit doses from a licensed radiopharmacy or prepared from a Tc-99m generator received weekly. All waste was stored for decay in storage or returned to the radiopharmacy.

The radiation oncology department performed 25 prostate implants annually using palladium-103 seeds, and approximately four temporary seed implants annually using cesium-137 seeds. In addition, the oncology staff performed approximately one radiopharmaceutical therapy annually using samarium-153. The oncology staff consisted of one radiation oncologist, one dosimetrist, one dosimetrist in training, and contract physicists from an area physics group.

The licensee's facility on Katy Lane was a nuclear cardiology clinic. One technologist performed approximately 120 cardiology procedures monthly using technetium-99m unit doses delivered from a licensed radiopharmacy. All waste was stored for decay or returned to the radiopharmacy. This was a new location added since the previous inspection. The facility was consistent with the information provided to the NRC.

Performance Observations

The inspector observed one diagnostic administrations of licensed material including dose preparation and disposal, as well as a prostate seed implant procedure, including follow-up surveys. Licensee staff demonstrated package receipt surveys, survey meter and wipe counter QC, and dose calibrator constancy checks, and described generator elution, kit preparation, molybdenum breakthrough tests, temporary seed implant procedures, and radiopharmaceutical therapy procedures. The inspector noted no concerns with these activities except as described below. The inspector reviewed written directives for radiopharmaceutical and seed implant procedures and found no issues. Interviews with licensee staff indicated adequate knowledge of radiation safety procedures. Radiation surveys indicated radiation levels consistent with licensee records and postings.

At the licensee's facility on Katy Lane, the technologist did not have access to a survey instrument for performing daily surveys because the meter had been sent for calibration around May 14, 2008. Licensee personnel believed that they were not required to perform daily surveys in this area because 10 CFR 35.70(a) requires such surveys only in areas where procedures requiring written directives were performed. However, the licensee's procedures submitted as part of their application in September 2001 required a daily survey with a radiation detection survey meter for all injection areas. While the technologist performed daily wipe surveys of the area, such a survey would not detect fixed contamination. The technologist was provided a spare survey instrument from the main nuclear medicine area at the hospital before the end of the inspection.