

**SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION**

<p>1. LICENSEE/LOCATION INSPECTED: Clarian West Medical Center 1111 Ronald Reagan Parkway Avon, Indiana 46123</p> <p>REPORT NUMBER(S)                      2009-001</p>	<p>2. NRC/REGIONAL OFFICE</p> <p><b>Region III</b> <b>U.S. Nuclear Regulatory Commission</b> <b>2443 Warrenville Road, Suite 210</b> <b>Lisle, Illinois 60532-4351</b></p>	
<p>3. DOCKET NUMBER(S) 030-36611</p>	<p>4. LICENSEE NUMBER(S) 13-32526-01</p>	<p>5. DATE(S) OF INSPECTION November 16, 2009</p>

**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.

1 Non-Cited Violation(s) was/were discussed involving the following requirement(s) and Corrective Action(s):  
*Licensee procedure requires performing linearity on the dose calibrator at least quarterly. Contrary to the above, licensee personnel failed to perform linearity test on the dose calibrator between January 2, 2009, and October 22, 2009. No corrective action, licensee performed the linearity test at the first opportunity. This is considered a Non-Cited Violation because it was licensee-identified, licensee-corrected, non-repeat, and non-willful.*

- 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	Sarah Gerster Assistant Mgr Diagnostic Imaging	<i>Sarah Gerster</i>	11/16/09
NRC INSPECTOR	Geoffrey M. Warren	<i>G M Warren</i>	11/16/09

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6. INSPECTION PROCEDURES USED 87130		7. INSPECTION FOCUS AREAS 03.01 – 03.08	

**SUPPLEMENTAL INSPECTION INFORMATION**

1. PROGRAM CODE(S) 02121	2. PRIORITY 5	3. LICENSEE CONTACT Robert T. Anger, RSO	4. TELEPHONE NUMBER 317-962-3572
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<input checked="" type="checkbox"/> Main Office Inspection	Next Inspection Date: <u>Nov. 2014</u>
<input type="checkbox"/> Field Office	
<input type="checkbox"/> Temporary Job Site Inspection	

**PROGRAM SCOPE**

The licensee was a 85-bed hospital located in Avon, Indiana, with authorization to use byproduct materials in Sections 35.100 and 35.200, who saw patients primarily from the Indianapolis metropolitan area. Licensed activities were conducted only at the location indicated on the license. The nuclear medicine department was staffed with two full-time nuclear medicine technologists, who typically administered 200 diagnostic doses monthly. The licensee performed bone, hepatobiliary, gastric, and other studies using unit doses received from a licensed nuclear pharmacy. The doses were primarily technetium-99m. All waste was either held for decay-in-storage (DIS) or returned to the nuclear pharmacy.

**Performance Observations**

The inspector observed one diagnostic administration of licensed material, including preparation and disposal. The technologists demonstrated survey meter and well counter QC, package receipt surveys and wipes, dose calibrator constancy checks, and daily contamination surveys, and described a variety of diagnostic procedures and weekly wipe surveys. The inspector noted no concerns with these activities. Interviews with licensee personnel indicated adequate knowledge of radiation safety concepts and procedures. The inspector performed independent and confirmatory radiation measurements which indicated results consistent with licensee survey records and postings.

The inspector determined that the licensee had not performed linearity testing on the dose calibrator between January and October 2009. As corrective action, the licensee had performed the check when it was determined that it had been missed, and stated they would be more careful about ensuring it was done in the future. This was categorized as a non-cited violation because the licensee identified and corrected the violation prior to the inspection, and the violation was neither willful nor repeat.