NRC FORM 591M PART 1
(07-2012)
10 CFR 2.201

U.S. NUCLEAR REGULATORY COMMISSION

SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE/LOCATION INSPECTED:	2. NRC/REGIONAL OFFICE
Acquisition Bell Hospital, LLC d/b/a Bell Hospital 901 Lakeshore Drive Ishpeming, Michigan 49849 REPORT NUMBER(S) 2018001	Region III U. S. Nuclear Regulatory Commission 2443 Warrenville Road, Suite 210 Lisle, IL 60532-4352

3. DOCKET NUMBER(S)	4. LICENSE NUMBER(S)	5. DATE(S) OF INSPECTION
030-13856	21-02037-03	August 23, 2018

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 violations(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, to exercise discretion, were satisfied.

Non-cited violation(s) were discussed involving the following requirement(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 in accordance with NRC Enforcement Policy. This form is a NOTICE OF VIOLATION, which may be subject to posting in accordance with 10 CFR 19.11.

(Violations and Corrective Actions)

Contrary to License Condition 14.A of NRC License No. 21-02037-03 and Item 3 of the licensee's procedure for preparing, drawing up and injecting radiopharmaceuticals, a member of the licensee's staff failed to wear their whole body dosimeter while performing injections of radiopharmaceuticals. Specifically, a nuclear medicine technologist (NMT) misplaced their whole body dosimeter on or about August 20, 2018 and continued to perform injections of radiopharmaceuticals without it through August 23, 2018.

The root cause of this violation was lack of communication between the NMT and the licensee's radiation safety personnel regarding the lost dosimeter. As corrective action, licensee staff searched for and found the missing dosimeter on August 23, 2018, to use for future administrations within the monitoring period.

Continued on Part 2

Statement of Corrective Actions

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	Todd Bostwick	Todd Bostwick	9-13-18
NRC INSPECTOR	Edward F. Harvey	Edward Harvey	9/10/2018
BRANCH CHIEF	Aaron T. McCraw	for ATM	9/10/18

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(Continued)

Continued from Part 1

In addition, on August 28, 2018, the RSO prepared a dose estimate for the days on which the dosimeter was missing based on the previous dose history for the NMT. The licensee has committed to submitting the dose calculation to their dosimetry service provider at the end of the monitoring period to maintain a more accurate dose of record. As long term corrective action to prevent recurrence, the licensee amended their contract with their dosimetry provider to include a spare dosimeter that may be used in the event of a future lost dosimeter. The inspector reviewed the purchase order and confirmed that the spare dosimeter was ordered and would be sent with the batch of dosimeters to be used during the next monitoring period.

This is a Severity Level IV violation.

NRC FORM 591M PART 3
(07-2012)
10 CFR 2.201

U.S. NUCLEAR REGULATORY COMMISSION

Docket File Information

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6. INSPECTION PROCEDURES USED	7. INSPECTION FOCUS AREAS
87131	All

SUPPLEMENTAL INSPECTION INFORMATION

1. PROGRAM CODE(S)	2. PRIORITY	3. LICENSEE CONTACT	4. TELEPHONE NUMBER
02120	3	Todd Botswick, MD - RSO	(906) 486-4431

|✓| Main Office Inspection Next Inspection Date: August 23, 2021

| | Field Office Inspection

| | Temporary Job Site Inspection

PROGRAM SCOPE

This was an unannounced routine inspection of a hospital authorized to use byproduct material for diagnostic and therapeutic medical procedures permitted by 10 CFR 35.100, 35.200, and 35.300. The nuclear medicine department was staffed with one full time nuclear medicine technologists (NMT) who performed approximately 40 diagnostic administrations per month, Monday through Friday. The licensee received a Mo/Tc-99 generator every two weeks to prepare doses for diagnostic administrations of Tc-99M. Although authorized, the licensee had not performed any therapeutic administrations of radiopharmaceuticals since the last inspection. The licensee retained the services of a medical physicist consultant to perform annual audits of the radiation safety program.

The inspector toured the nuclear medicine department to evaluate the licensee's measures for materials security, hazard communication, and exposure control. The inspector conducted independent and confirmatory surveys of these facilities and found no residual contamination or exposures to members of the public in excess of regulatory limits. The inspector observed both rest and stress administrations of Tc-99M for a cardiac stress test. Licensee staff also demonstrated and discussed procedures for package receipt, area surveys, spill response, and waste handling. Through these observations and discussions, the inspector found the licensee's staff to be knowledgeable of radiation protection principles.

The inspector reviewed a selection of relevant records, including equipment calibrations, consultant audits, source inventories, molybdenum breakthrough tests, and dosimetry reports.

One violation of NRC requirements, described in Parts 1 and 2 of this report, was identified during this inspection.

GW for
ATM
9/10/18