UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

MAY 13 1994

Docket No. 030-01215
License No. 04-00689-07
EA No. 93-203

Department of Veterans Affairs Medical Center
ATTN: Jule Moravec, Director
VA Medical Center, Long Beach
5901 East Seventh Street
Long Beach, California 90822

SUBJECT: NOTICE OF VIOLATION
(NRC INSPECTION REPORT NO. 030-01215/93-01)

This refers to the inspection conducted on July 19-23 and 30, 1993 of Veterans Affairs Medical Center (VAMC) Long Beach, California. The results of the inspection were documented in NRC Inspection Report No. 030-01215/93-01, dated August 24, 1993. The inspectors identified apparent violations of NRC requirements. The apparent violations, their causes, and your corrective actions were discussed with you during an Enforcement Conference on August 30, 1993. Based on additional information that you provided during and after the Enforcement Conference, a number of apparent violations are not being cited. The remaining violations are described in the enclosed Notice of Violation (Notice).

Three violations were repeated from the NRC inspection performed on March 25-29, 1991: 1) failure to maintain a record of the disposal of radioactive waste as required by 10 CFR 35.92(b), 2) failure to monitor hands and feet after each procedure or prior to leaving the area as required by License Condition 18, and 3) failure to perform surveys in areas where licensed material is used or stored as required by License Condition 18. The failure to prevent recurrence of these violations indicates that management had not adequately monitored the licensed program. Although these violations have been categorized at Severity Level IV, further repetition will result in consideration of escalated enforcement action.

The results of the Enforcement Conference and the information your staff provided to the NRC after the conference are documented in NRC Enforcement Conference Report No. 93-02, which is enclosed. This report describes a number of apparent violations that are not being cited and explains the reasons. Additionally, failure to provide bioassays for individuals processing greater than ten millicuries of iodine in a ninety day period as specified in Regulatory Guide 8.20 is not being cited based on the RSO's statements that even though a single laboratory may have received greater than ten millicuries of iodine, no one individual processed more than ten millicuries in a ninety day period.

Finally, the NRC staff, after consulting with the Commission, has determined that an error involving the administration of a diagnostic radiopharmaceutical

IE07
1/1

HQ DISTRIBUTION:
PDR
SECY
CA
HThompson, DEDS
RBernero, NMSS
CPaperiello, NMSS
LChandler, OGC
JLieberman, OE
JGoldberg, OGC
Enforcement Coordinators
RI, RII, RIII, WCFO
FIngram, OPA
DWilliams, OIG
BHayes, OI
PLohaus, OSP
EJordan, AEOD
PSantiago, OE
JDelMedico, OE
EA File
DCS

RIV DISTRIBUTION:
JCallan
JMontgomery
ABBeach
SCollins
KPerkins▸FWenslawski (via e-mail)
JGilliland
CHackney
WBrown
GSanborn▸EAFile
RIV Files
MIS Coordinator

RIV:EO	DRA	RA
GFSanborn/cjg	JMMontgomery	LJCallan
5/ /94	5/ /94	5/11/94