NRC FORM 592M
(10-2020)

U.S. NUCLEAR REGULATORY COMMISSION

Materials Inspection Record

1. Licensee Name:	2. Docket Number(s):	3. License Number(s)
North Ottawa Community Hospital	030-02168	21-13963-01

4. Report Number(s):	5. Date(s) of Inspection:
2021-001	June 22, 2021

6. Inspector(s):	7. Program Code(s):	8. Priority:	9. Inspection Guidance Used:
Ryan Craffey	02121	5	87130

10. Licensee Contact Name(s):	11. Licensee E-mail Address:	12. Licensee Telephone Number(s):
Dawn Edwards - Consultant	dedwards@mpcphysics.com	734-662-3197

13. Inspection Type:
- ☐ Initial
- ☑ Routine
- ☐ Announced
- ☐ Non-Routine
- ☑ Unannounced

14. Locations Inspected:
- ☑ Main Office
- ☐ Field Office
- ☐ Temporary Job Site
- ☐ Remote

15. Next Inspection Date (MM/DD/YYYY): 06/22/2026
- ☑ Normal
- ☐ Extended
- ☐ Reduced
- ☐ No change

16. Scope and Observations:

This was an unannounced routine inspection of an independent community health system authorized to perform diagnostic administrations of radiopharmaceuticals at its 81-bed hospital in Grand Haven, Michigan. At the time of the inspection, the licensee employed two part-time and one per diem technologist, who administered five to six unit doses per day, Monday through Friday. The licensee retained the services of a medical physics consultant to perform quarterly audits of the radiation safety program.

The inspector toured the hospital in Grand Haven. All areas were properly posted, and all licensed material was adequately secured. The inspector conducted independent and confirmatory surveys and found no residual contamination or exposures to members of the public in excess of regulatory limits. The inspector observed several administrations of Tc-99m radiopharmaceuticals and noted the use of adequate ALARA practices and contamination control measures. The inspector also observed package receipt surveys and verified the licensee's latest inventory of sources. The inspector interviewed the licensee's primary nuclear medicine technologist and found her to be knowledgeable of radiation protection principles and regulatory requirements. The inspector also reviewed a selection of records related to the radiation safety program program, including quarterly consultant audits, dose calibrator and well counter quality control checks, sealed source inventories and leak test results, survey meter calibration documentation, personnel dosimetry reports, and documentation of current hazmat refresher training.

The inspector identified a SLIV violation of LC 15.A for the licensee's failure to implement procedures for safe use of radioactive material as it committed to in its renewal application dated May 25, 2011. The primary technologist did not wear a finger TLD ring during the preparation, assay, and administration of nineteen doses containing Tc-99m between June 14 and June 22, 2021, as she had not been issued one prior to starting work with the licensee.

The inspector determined the root cause of the violation was a lack of adequate oversight of the program. The previous primary technologist, who recently passed away, had maintained nearly full responsibility for dosimetry and various other elements of the program. As corrective action, the technologist committed to wear an unused ring dosimeter issued to the previous primary technologist until she could obtain one of her own from the dosimetry provider. The licensee's consultant committed to evaluate the extent of the technologist's unrecorded dose, to transfer any dose received on the previous primary technologist's current badge to the new primary technologist, and to ensure that additional staff and management were involved in oversight of the program. The licensee also ordered and committed to maintain spare badges.

The inspector held an exit meeting with the RSO and physics consultant via videoteleconference on July 9, 2021.