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
Department of the Army General Leonard Wood Army Community Hospital 126 Missouri Ave. Fort Leonard Wood, MO 65473 REPORT NUMBER(S) 2019001	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
030-08561	24-15095-01	August 8, 2019, with in-office review to August 14, 2019

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 10 CFR 35.40(b)(1), on November 9, 2016, the licensee failed to include the dosage on a written directive for an administration of a quantity greater that 30 microcuries of sodium iodide iodine-131 (15.1 millicuries).

The root cause was an isolated oversight by the licensee. Despite not including the dosage on the written directive, the licensee delivered the intended dosage in accordance with the physician authorized user's treatment order and within acceptable tolerances permitted by the regulations. As corrective actions, the RSO provided training in the requirements of 10 CFR 35.40(b)(1) to authorized users listed on the licensee for material described in 10 CFR 35.300 and the nuclear medicine technologists. The RSO will also include a review of all written directives when he conducts his weekly audits of the nuclear medicine department.

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	Raymond H. Meyer Jr.		8/30/2019
NRC INSPECTOR	Kevin G. Null		8/30/19
BRANCH CHIEF	Aaron T. McCraw		08/30/2019

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
2120	3	Captain Raymond Meyer, Jr. RSO	(573) 596-9879

☑ Main Office Inspection Next Inspection Date: August 14, 2022

☐ Field Office Inspection

☐ Temporary Job Site Inspection

PROGRAM SCOPE

This was a routine, unannounced inspection of a nuclear medicine department that was authorized to use material described in 10 CFR 35.100, 200, and 300. The licensee employed two full-time certified nuclear nuclear medicine technologists (CNMTs), a radiology manager, and a radiation safety officer (RSO). The licensee performed an average of 15 diagnostic studies each day in 2 imaging rooms. Licensed material was received in the form of unit doses from a local radiopharmacy. The licensee had not performed any therapy procedures in over a year.

PERFORMANCE OBSERVATIONS

The inspector toured the department and interviewed both CNMT's, the RSO, and the radiology manager. Staff members described the process for ordering and receiving licensed material including package surveys and action levels, and daily constancy checks of the dose calibrator. The CNMTs demonstrated daily dose calibrator checks, daily radiation level surveys and weekly smears for contamination, and security of the hot lab. The inspector reviewed dose calibrator daily constancy records, written directives (WD) issued since the last inspection for iodine-131 treatments, survey meter calibration records, package receipt records and associated package surveys, dosimetry reports, and results of weekly audits performed by the RSO.

The inspector verified that the licensee implemented adequate corrective actions in response to a violation regarding the daily constancy check of the dose calibrator that was issued during the last NRC inspection May 2016. The inspector determined that the licensee has performed adequate daily constancy checks of the dose calibrator through interviews, demonstrations, and a review of records since the violation was identified. The inspector also determined that the violation has not recurred. As such, this violation is closed.

The inspector identified one new violation of NRC requirements, as documented on Part 1, during this inspection.