



**UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II**

245 PEACHTREE CENTER AVENUE NE, SUITE 1200
ATLANTA, GEORGIA 30303-1257

November 10, 2016

Mr. Mano Nazar
President and Chief Nuclear Officer
Florida Power and Light Company
Mail Stop: NT3/JW
15430 Endeavor Drive
Jupiter, FL 33478

**SUBJECT: TURKEY POINT NUCLEAR GENERATING STATION - NRC INTEGRATED
INSPECTION REPORT 05000250/2016003, 05000251/2016003**

Dear Mr. Nazar:

On September 30, 2016, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Turkey Point Nuclear Generating Station Units 3 and 4. On October 13, 2016, the NRC inspectors discussed the results of the inspection with Mr. Summers and other members of your staff. The results of this inspection are documented in the enclosed report.

NRC inspectors documented three findings of very low safety significance (Green) in this report. Three of these findings involved violations of NRC requirements; one of these violations was determined to be a Severity Level IV violation under the traditional enforcement process, with no associated finding. The NRC is treating these violations as non-cited violations (NCVs) consistent with Section 2.3.2.a of the NRC Enforcement Policy.

If you contest the violations or significance of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region II; the Director, Office of Enforcement; and the NRC Resident Inspector at Turkey Point Nuclear Generating Station Units 3 and 4.

If you disagree with a cross-cutting aspect assignment in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region II; and the NRC resident inspector at the Turkey Point Nuclear Generating Station Units 3 and 4.

This letter, its enclosure, and your response (if any) will be made available for public inspection and copying at <http://www.nrc.gov/reading-rm/adams.html> and in the NRC Public Document Room in accordance with 10 CFR 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,

/RA/

LaDonna B. Suggs, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Docket Nos.: 50-250, 50-251
License Nos.: DPR-31, DPR-41

Enclosure: Inspection Report 05000250/2016003, 05000251/2016003,
w/Attachment: Supplemental Information

cc w/encl.: Distribution via ListServ

Letter to Mano Nazar from LaDonna B. Suggs dated November 10, 2016.

SUBJECT: TURKEY POINT NUCLEAR GENERATING STATION - NRC INTEGRATED
INSPECTION REPORT 05000250/2016003, 05000251/2016003

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos: 50-250, 50-251

License Nos: DPR-31, DPR-41

Report Nos: 05000250/2016003, 05000251/2016003

Licensee: Florida Power & Light Company (FP&L)

Facility: Turkey Point Nuclear Generating Station, Units 3 & 4

Location: 9760 S. W. 344th Street
Homestead, FL 33035

Dates: July 1 to September 30, 2016

Inspectors: J. Reyes, Senior Resident Inspector (Acting)
M. Thomas, Resident Inspector (Acting)
A. Wilson, Project Engineer (section 4OA3)
A. Alen, Resident Inspector (section 1R04, 1R22)

Approved by: LaDonna B. Suggs, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000250/2016003, 05000251/2016003; 07/01/16 – 9/30/16; Turkey Point Nuclear Generating Station, Units 3 & 4; Flood Protection Measures; Problem Identification and Resolution; Follow-up of Events and Notices of Enforcement Discretion.

The report covered a three-month period of inspection by the resident inspectors and a regional inspector. The NRC inspectors documented three non-cited violations of NRC requirements. The significance of inspection findings are indicated by their color (i.e., greater than Green, or Green, White, Yellow, Red) and determined using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process," (SDP) dated April 29, 2015. The cross-cutting aspects were determined using IMC 0310, "Aspects Within the Cross-Cutting Areas," dated December 4, 2014. All violations of NRC requirements were dispositioned in accordance with the NRC's Enforcement Policy dated August 1, 2016. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 6.

NRC-Identified and Self-Revealing Findings

Cornerstone: Mitigating Systems

- Green: The NRC inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 6.8.1, for the licensee's failure to implement required housekeeping controls in the 4A residual heat removal (RHR) pump room to ensure flood protection devices would not be damaged or otherwise clogged. Specifically, the licensee's failure to adequately implement station housekeeping procedure MA-AA-100-1008 to ensure flood protection devices in the 4A RHR pump room were not challenged was a performance deficiency. Immediate corrective actions included removing the debris, entering this issue into the corrective action program (CAP), and initiating a past-operability review.

The inspectors determined the performance deficiency to be more than minor because it was associated with the protection against external factors attribute of the mitigating systems cornerstone and there was reasonable doubt of operability which if left uncorrected could have adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Using Manual Chapter 0609, Appendix A, "The Significance Determination Process for Findings-At-Power," the inspectors screened the finding as Green because it did not involve the total loss of any safety function. The inspectors assigned a cross cutting aspect in the area of human performance associated with the work management element because the organization failed to adequately implement a process to control work activities in a high-risk flood area, and did not adequately identify and manage risk associated with the flood-sensitive area [H.5] (Section 1R06).

- Green: A self-revealed Green finding and associated Non-cited Violation (NCV) of Technical Specification (TS) Limiting Condition for Operation (LCO) 3.6.2.2 was identified for the failure to properly insert the control power fuse for the 3B Emergency Containment Cooler (ECC) fan. The ECC unit was determined to be inoperable for greater than the allowed outage time of 72 hours and the actions required by TS LCO 3.6.2.2, Action A, were not taken.

An immediate corrective action was taken to adjust the fuse holder clips on the 3B ECC breaker to provide a tight fit. Additional corrective actions initiated by the licensee in AR 2108256 included a review of recently replaced similar breakers on Units 3 and 4 to identify and schedule inspection of fuse tightness.

The inspectors determined that the finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of Equipment Performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the 3B ECC was not available to automatically start upon receipt of a safety injection signal, and during periods with two ECCs concurrently inoperable, the ECC system would not have been able to perform its specified safety function. To determine the significance of the finding, a Senior Reactor Analyst performed a bounding risk assessment by failing all three containment coolers in the Turkey Point Standardized Plant Analysis Risk (SPAR) model for the entire exposure time of 72 days. The dominant accident sequence was a very small loss of coolant accident (LOCA) where high head safety injection fails for independent reasons. The delta-core damage frequency (CDF) due to the performance deficiency was $1E-8$. The low risk result was driven by the low frequency of LOCAs, the limited exposure time, and the low risk value of the containment coolers themselves. The finding was determined to be of very low safety significance (Green). This finding was assigned a cross cutting aspect associated with the avoid complacency element of the human performance area because the licensee failed to confirm fuse holder tightness following implementation of breaker maintenance. The licensee failed to recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while executing successful outcomes. [H.12] (Section 4OA3)

Other Findings

- Severity Level IV: The NRC identified an NCV of 10 CFR 50.70, "Inspections," paragraph (b)(4), for the licensee's failure to ensure that the arrival and presence of an NRC inspector is not communicated to persons at the facility. The licensee's actions of announcing the presence and location of an NRC inspector during an unannounced inspection in the protected area was a performance deficiency. Interim corrective actions included providing a site-wide communication to all employees and providing training briefs during shift turnovers informing employees of the regulation. The licensee entered this issue into the CAP as AR 2155881.

The NRC evaluated this issue under the traditional enforcement process because the act of announcing NRC presence could impact NRC ability to perform its regulatory function. Specifically, the NRC relies on its ability to perform unannounced inspections to evaluate licensee performance, and communicating the presence and location of NRC inspectors affects their ability to perform these inspections, and as such the regulatory function is impacted. Because the violation was determined to be of very low safety significance, was not repetitive or willful, and was entered into the CAP, this violation is being treated as a Severity Level IV non-cited violation consistent with the NRC Enforcement Policy. This violation was evaluated under the traditional enforcement process and thus does not have a cross cutting aspect (Section 4OA2).

Licensee-identified Violations

None.

REPORT DETAILS

Summary of Plant Status

Unit 3 began this inspection period at 100 percent of Rated Thermal Power (RTP). On July 27 and 29, RTP was reduced to 82 and 54 percent, respectively, to perform repairs on the 3B feedwaterheater. On July 30, the Unit was manually tripped due to water hammer issues that developed while executing a clearance for repairing the 3B feedwater heater. The unit returned to 100 percent RTP on August 3, where it remained through the end of this inspection period.

Unit 4 began this inspection period at 100 percent of RTP where it remained through the end of this inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R01 Adverse Weather Protection

.1 Readiness for Impending Adverse Weather Conditions

a. Inspection Scope

During the week of August 26th, the inspectors reviewed the status of licensee actions in accordance with Administrative Procedure 0-ADM-116, Hurricane Season Readiness, and 0-ONOP-103.3, Severe Weather Preparations, when tropical disturbance #9, which was forecast to escalate to a tropical storm or hurricane, approached the Florida peninsula. The inspectors verified actions associated with the procedures and special equipment were performed and staged or available as directed by the procedures. The inspectors performed a walk down of the following areas to identify any potential adverse conditions. This inspection constitutes one sample.

- Unit 3 and Unit 4 turbine buildings
- Unit 3 and Unit 4 emergency diesel generator (EDG) engine buildings
- Unit 3 and Unit 4 intake cooling water (ICW) systems and structures
- Auxiliary feedwater system area
- Switchyard area

b. Findings

No findings were identified.

1R04 Equipment Alignment

.1 Partial Equipment Walk Downs (Quarterly)

a. Inspection Scope

The inspectors conducted four partial alignment verifications of the safety-related systems listed below.

These inspections included reviews using plant lineup procedures, operating procedures, and piping and instrumentation drawings, which were compared with observed equipment configurations to verify that the critical portions of the systems were correctly aligned to support operability. The inspectors also verified that the licensee had identified and resolved equipment alignment problems that could cause initiating events or impact the capability of mitigating systems or barriers by entering them into the corrective action program (CAP). Documents reviewed are listed in the Attachment. This inspection constitutes four samples.

- 3B RHR while the 3A RHR pump was out of service (OOS)
- 3B EDG while the 3A EDG was OOS
- 4B EDG while the 4A EDG was OOS
- 4A ICW header while the 4B ICW header was OOS

b. Findings

No findings were identified.

1R05 Fire Protection

.1 Fire Area Walk downs

a. Inspection Scope

The inspectors walked down the plant areas described below to evaluate conditions related to control of transient combustibles, ignition sources, material condition, and operational status of fire protection systems including fire barriers used to prevent fire damage and propagation. The inspectors reviewed these activities using provisions in the licensee's procedure 0-ADM-016, "Fire Protection Plan" and 10 CFR Part 50, Appendix R. The inspectors routinely reviewed the licensee's fire impairment lists and monitored the associated corrective actions for completion. The inspectors reviewed the action request report database to verify that fire protection problems were being identified and appropriately resolved in the CAP. The inspectors' tours of the selected areas verified the fire protection equipment was installed as shown on the applicable fire plan drawings and appeared functional and ready for usage. This inspection constitutes six samples.

- Unit 4 Containment spray pump area
- Unit 3 A and B safety-related 4160-volt switchgear rooms
- Unit 3 A and B safety-related 480-volt load center rooms
- Unit 3 and Unit 4 cable spreading room
- Unit 3 and Unit 4 elevation 30 3A and 4B battery rooms and DC equipment rooms
- Unit 3 and Unit 4 control room, and 3B and 4A DC equipment rooms

b. Findings

No findings were identified.

1R06 Flood Protection Measures

a. Inspection Scope

The inspectors conducted a walk down of the Unit 4A residual heat removal (RHR) pump room to verify that flood protection measures were in accordance with design specifications. The inspectors reviewed the Turkey Point Updated Final Safety Analysis Report (UFSAR), Appendix 5F, Internal Plant Flooding, which discussed protection of areas containing safety-related equipment that could be affected by internal flooding. Specific plant attributes that were checked included structural integrity, sealing of penetrations, sump pump configurations, and control of debris. The inspectors verified sump systems, including alarms, to be functional. This inspection constitutes one sample.

b. Findings

Introduction: The NRC identified a green non-cited violation (NCV) of Technical Specification (TS) 6.8.1, for the licensee's failure to implement required housekeeping controls specified by procedure MA-AA-100-1008, "Station Housekeeping and Material Control." The failure to adequately implement station housekeeping procedure was a performance deficiency.

Description: On September 13, 2016, the inspectors identified debris which had been in place for approximately two weeks. The debris consisted of rags, gloves, safety goggles, and other tooling on the floor of the 4A RHR pump room. This debris had the potential to clog the sump screen and render the internal flood mitigation feature inoperable. Additionally, the inspectors identified other debris such as a power drill, scaffold poles and boards, and a bag of scaffolding hardware, unsecured and uncontrolled per station procedure. Work was on hold and there was no active work in progress.

As described in Appendix 5F, "Internal Plant Flooding," of the licensee's UFSAR, the RHR pump rooms require protection from internal flooding due to the potential of a fire protection system pipe break since the rooms are located below grade. As a mitigation feature, the licensee's design employs a sump system in the room designed sufficiently for precluding an internal flood event which would render the RHR pumps inoperable. The RHR pump rooms are also equipped with sump level alarms, which are powered from a vital source and annunciate in the control room to notify operators of an abnormal condition in the room.

Following work on the 4A RHR pump suction valve, the inspectors observed debris left behind by maintenance crews that had the potential to clog the entire sump screen during an internal flood event. The licensee took immediate corrective action to remove the debris, initiated AR 02155629, and performed a past-operability review. The licensee determined from the past-operability review that the sump system remained functional.

Analysis: The inspectors determined that the licensee's failure to adequately implement station housekeeping procedure MA-AA-100-1008 was a performance deficiency. Specifically, the licensee's failure to maintain the 4A RHR pump room free of debris during work activities, as required by Step 4.5.1.B of procedure MA-AA-100-1008, and

Step 1.2, Step 2.11, Step 5.3, and Step 9.4 of Attachment 1 to procedure MA-AA-100-1008, led to an unnecessary challenge to the 4A RHR pump room's main flood mitigation feature, the sump pump. Technical Specification 6.8.1 requires written procedures required by the licensee's Quality Assurance Topical Report (QATR) be established, implemented, and maintained. The QATR includes procedures listed in Appendix A of NRC Regulatory Guide 1.33, Revision 2, dated February 1978, including procedures for the control of maintenance. The QATR also commits to NRC Regulatory Guide 1.39, Revision 2, dated September 1977, specifying housekeeping requirements for operating nuclear power plants. The licensee implements TS 6.8.1 requirements, in part, using NextEra Fleet Administrative Procedure MA-AA-100-1008, "Station Housekeeping and Material Control." Step 4.5.1.B of procedure MA-AA-100-1008 and several steps of Attachment 1 to procedure MA-AA-100-1008, including Step 1.2, 2.11, 5.3, and 9.4, require that work-area cleanliness be maintained to ensure flood protection devices (e.g. sumps) are not damaged or otherwise clogged. The performance deficiency was more than minor, because it was associated with the protection against external factors attribute of the mitigating systems cornerstone and there was reasonable doubt of operability which if left uncorrected could have adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage).

The finding was screened using IMC 0609, Attachment 4, "Initial Characterization of Findings," Table 2, under the mitigating systems cornerstone for external event (flood), dated July 1, 2012, and IMC 0609 Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2 for mitigating systems and Exhibit 4 for external events, dated July 1, 2012. The inspectors determined the finding was of very low safety significance (Green) because the finding was related to an external event mitigation system (flood) and did not involve the total loss of any safety function. This finding was assigned a cross cutting aspect associated with the work management element of the human performance area because the licensee failed to adequately implement a process to control work activities in a high-risk flood area, and did not adequately identify and manage risk associated with the flood-sensitive area (H.5).

Enforcement: Technical Specification 6.8.1 requires written procedures required by the licensee's Quality Assurance Topical Report (QATR) be established, implemented, and maintained. TS 6.8.1 requires implementation of MA-AA-100-1008, "Station Housekeeping and Material Control." Step 4.5.1.B and several steps of Attachment 1, including Step 1.2, 2.11, 5.3, and 9.4, require that work-area cleanliness be maintained to ensure flood protection devices (e.g. sumps) are not damaged or otherwise clogged. Contrary to this requirement, on September 13, 2016, NRC inspectors identified the failure to establish required housekeeping controls to ensure flood protection devices would not be damaged or clogged in the 4A RHR pump room. During the approximate two week period that this condition existed there was reasonable doubt of operability of the 4A RHR pump room sump pump to complete its internal flood mitigation function. The licensee took immediate corrective actions to remove the debris from the 4A RHR pump room and initiated a past-operability review. This violation is being treated as an NCV, consistent with Section 2.3.2.a of the Enforcement Policy, because the issue was of very low safety significance and was entered into the licensee's CAP as AR 02155629. (NCV 05000251/2016003-01, Failure to provide adequate flood protection for the 4A RHR train).

1R07 Heat Sink Performance

a. Inspection Scope

The inspectors selected the 4B component cooling water heat exchanger to verify that the licensee was performing periodic cleaning and testing following maintenance in accordance with associated procedures. The inspectors observed portions of the heat exchanger cleaning performed by the licensee under WO 40485184. The inspectors verified the cleaning and inspection following maintenance was performed and properly documented in accordance with completed maintenance procedure 0-PMM-030.01, "Component Cooling Water Heat Exchanger Cleaning and Inspection." The inspectors also reviewed completed licensee procedure 4-OSP-030.4, "Component Cooling Water Heat Exchanger Performance Test," and 4-OSP-019.4, "Component Cooling Water Heat Exchanger Performance Monitoring" to ensure the heat exchanger was restored, leak tested, and returned to service with no deficiencies. The inspectors walked down portions of the cooling systems for integrity checks and to assess operational lineup and material condition. This inspection constitutes one sample.

b. Findings

No findings were identified.

1R11 Licensed Operator Requalification Program

.1 Resident Inspector Quarterly Review Simulator Observation

a. Inspection Scope

The inspectors performed the following inspection samples of simulator observations and assessed licensed operator performance while training. These observations included procedural use and adherence, response to alarms, communications, command and control, and coordination and control of the reactor plant operations.

On July 25 and August 3, 2016, the inspectors assessed licensed operator performance in the plant-specific simulator during training evolutions. The scenario included a loss of the 3A EDG sequencer followed by a turbine trip followed by an anticipated transient without a scram (ATWS) and a main steam line break inside containment.

During these simulator observations, the simulator board configurations were compared with actual plant control board configurations reflecting recent plant changes or modifications. The inspectors specifically evaluated the following attributes related to operating crew performance and the licensee evaluation:

- Clarity and formality of communication
- Ability to take timely action to safely control the unit
- Prioritization, interpretation, and verification of alarms
- Correct use and implementation of off-normal and emergency operating procedures and emergency plan implementing procedures
- Control board operation and manipulation, including high-risk operator actions

- Oversight and direction provided by shift supervisor, including ability to identify and implement appropriate TS actions and emergency plan classification and notification
- Crew overall performance and interactions
- Evaluator's control of the scenario and post scenario evaluation of crew performance

This inspection constitutes two samples.

b. Findings

No findings were identified.

.2 Control Room Observations

a. Inspection Scope

The inspectors performed daily assessments of licensed operators in the control room during their performance of routine operations. These observations included daily surveillance testing and log keeping, response to alarms, communications, shift turnovers, and coordination of plant activities. These observations were conducted to verify operator compliance with station operating guidelines, such as use of procedures, control and manipulation of components, and communications.

The inspectors also performed the following focused control room observations during reactivity manipulations and Mode changes. These observations were conducted to verify operator compliance with station operating protocols as described in licensee procedure OP-AA-100-100, Conduct of Operations. The inspectors focused on the following conduct of operations attributes as appropriate:

- Operator compliance and use of procedures
- Control board manipulations
- Communication between crew members
- Use and interpretation of plant instruments, indications, and alarms
- Use of human error prevention techniques
- Documentation of activities, including procedure place keeping and narrative logs
- Supervision of activities, including risk and reactivity management

On July 29, 2016 inspectors observed the down power on Unit 3 from 82% to 54% RTP to support an expanded tag out on the B-train low pressure feedwater heaters. This inspection constitutes one sample.

b. Findings

No findings were identified.

1R12 Maintenance Effectiveness

a. Inspection Scope

The inspectors reviewed the following equipment problems and periodic evaluation reports to verify that the licensee's maintenance efforts met the requirements of 10 CFR

50.65, "Requirements for monitoring the effectiveness of maintenance at nuclear power plants," and licensee procedure ER-AA-100-2002, "Maintenance Rule Program Administration." The inspectors' efforts focused on maintenance rule scoping, characterization of maintenance problems and failed components, risk significance, determination of a(1) classification, corrective actions, and the appropriateness of established performance goals and monitoring criteria. The inspectors also interviewed responsible engineers and observed some of the corrective maintenance activities. The inspectors verified that equipment problems were being identified and entered into the corrective action program. The inspectors used licensee maintenance rule database, system health reports, and the CAP as sources of information on tracking and resolution of issues. This inspection constitutes two samples.

- AR 2108256, 3B emergency containment cooler entered into (a)(1)
- AR 2095631, B standby steam generator feed pump entered into (a)(1)

b. Findings

No findings were identified.

1R13 Maintenance Risk Assessments and Emergent Work Control

a. Inspection Scope

The inspectors completed in-office reviews and control room inspections of the licensee's risk assessment of emergent or planned maintenance activities. The inspectors verified the licensee's risk assessment and risk management activities using the requirements of 10 CFR 50.65(a)(4); the recommendations of Nuclear Management and Resource Council 93-01, "Industry Guidelines for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants;" and procedures WM-AA-203, "Online Scheduling Process," WM-AA-100-1000, "Work Activity Risk Management," and O-ADM-225, "On Line Risk Assessment and Management." The inspectors also reviewed the effectiveness of the licensee's contingency actions to mitigate increased risk resulting from the degraded equipment and the licensee assessment of aggregate risk using procedure OP-AA-104-1007, "Online Aggregate Risk." The inspectors discussed the on-line risk monitor (OLRM) results with the control room operators and verified all applicable out-of-service equipment was included in the OLRM calculation. The inspectors evaluated the following six risk assessment samples during the inspection period:

- 4A component cooling water pump and 4A EDG OOS
- 4B ICW header OOS
- Emergent unplanned trip of the 1A HVAC chiller that provides cooling to the safety-related 4KV switchgear and 480V load center while the 3B EDG was OOS during testing
- 3D 4160V vital bus OOS
- 3C component cooling water pump, 3B ICW header/basket strainer, 3B load center and switchgear room HVACs, and B auxiliary feedwater pump OOS
- 4A ICW header OOS

b. Findings

No findings were identified.

1R15 Operability Determinations and Functionality Assessments

a. Inspection Scope

The inspectors evaluated the technical adequacy of the licensee evaluations to ensure that TS operability was properly justified and the subject component or system remained available such that no unrecognized increase in risk occurred for the operability evaluations described in the ARs listed below. The inspectors reviewed applicable sections of the UFSAR to determine if the system or component remained available to perform its intended function. In addition, when applicable, the inspectors reviewed compensatory measures implemented to verify that the affected equipment remained capable of performing its intended design function. The inspectors also reviewed a sampling of condition reports to verify that the licensee was routinely identifying and correcting any deficiencies associated with operability evaluations. This inspection constitutes six samples.

- AR 02145330, FCV-4-498 air leak to controller
- AR 02148407, 3A EDG high jacket water temperature
- AR 02148392, MOV-6459A auxiliary feed water trip and throttle valve trip failure
- AR 02150292, 4V68A-4A EDG radiator fan #2 delayed start
- AR 01732759, Control room emergency ventilation system kitchen and toilet area exhaust dampers
- AR 02151078, 4-752A gear box housing broke on 4A RHR suction valve

b. Findings

No findings were identified.

1R18 Plant Modifications

a. Inspection Scope

The inspectors reviewed a permanent plant modification to the Unit 3 and Unit 4 control room emergency ventilation system associated with adding permanent steel plates over the kitchen area and toilet area exhaust ducts. The modification involved installation of two permanent, solid steel plates, one in the kitchen area exhaust duct and the other in the toilet area exhaust duct. Each plate was sealed to its respective exhaust duct using a silicone sealant and bolted to the concrete walls surrounding the exhaust ducts. The inspectors reviewed the 10 CFR 50.59 screening and technical evaluation to verify that the modification had not affected system operability or availability. The inspectors reviewed associated plant drawings, design analyses, and UFSAR documents impacted by this modification and discussed the changes with licensee personnel to verify that the modifications were consistent with the work order and associated documents. The inspectors observed portions of the modification and surrounding area to determine if conditions resulted in any potential unsafe conditions not described in the engineering change documentation. Additionally, the inspectors reviewed and verified that any

conditions associated with the modification were being identified and entered into the CAP. This inspection constitutes one sample.

- EC 249140, Control room emergency ventilation system kitchen and toilet boundary isolation

b. Findings

No findings were identified.

1R19 Post Maintenance Testing

a. Inspection Scope

For the post maintenance tests and associated WOs listed below, the inspectors reviewed the test procedures and either witnessed the testing or reviewed test records to determine whether the scope of testing adequately verified that the work performed was correctly completed and demonstrated that the affected equipment was operable. The inspectors verified that the requirements in licensee procedure MA-AA-203-1000, "Maintenance Testing," were incorporated into the test requirements. The inspectors reviewed the following WOs which consisted of six inspection samples:

- WO 40465913, 3A intake cooling water pump and motor replacement
- WO 40423975, Electric driven fire pump quarterly preventative maintenance
- WO 40474897, 4A EDG radiator fan control relay replacement
- WO 40425113, 4B component cooling water pump motor breaker 4AB13-PC3/TDPU relay replacement
- WO 40485515, 4A RHR pump suction valve 4-752A operator and reach rod replacement
- WO 40411437, 3B ICW header return to service after basket strainer PM

b. Findings

No findings were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors either reviewed or observed the following surveillance tests to verify that the tests met the TS requirements, the UFSAR description, the licensee's procedural requirements, and demonstrated the systems were capable of performing their intended safety functions and operational readiness. In addition, the inspectors evaluated the effect of the testing activities on the plant to ensure that conditions were adequately addressed by the licensee staff and that after completion of the testing activities, equipment was returned to the status required for the system to perform its safety function. The inspectors verified that any surveillance deficiencies were documented in the licensee's CAP. This inspection constitutes five surveillance test samples, and one in-service test (IST) sample.

The inspectors reviewed the following tests:

Surveillance Test:

- 3-OSP-023.1, 3A EDG monthly run
- 4-OSP-023.2, 4A EDG 24 hour run
- 0-OSP-074.3, Standby steam generator feed pump 'B' diesel
- 3-OSP-068.5B, 3B containment spray in-service test
- 0-OSP-075.11, C AFW pump in-service test

In-Service Tests:

- 4-OSP-068.5A, 4A containment spray in-service test

b. Findings

No findings were identified.

Cornerstone: Emergency Preparedness

1EP6 Drill Evaluation

.1 Licensed Operator Simulator Regualification

a. Inspection Scope

On August 3, 2016, the inspectors observed and assessed a licensed operator crew's performance during an evaluated licensed operator training scenario using the control room simulator. The simulated scenario included assessing classification of the emergency events and completing notifications to the State and NRC. The inspectors assessed the licensee's actions to verify that emergency classifications and notifications were timely and made in accordance with the licensee's emergency plan implementing procedures and 10 CFR 50.72 requirements. This inspection constitutes one sample.

b. Findings

No findings were identified.

.2 Emergency Preparedness Quarterly Drill

a. Inspection Scope

On September 20, 2016, the inspectors observed the simulator control room, technical support center, and emergency operating facility staff during a drill of the site emergency response organization to verify the licensee was properly classifying emergency events, making the required notifications, and making appropriate protective action recommendations. The drill scenario included prohibited access to a vital area due to release of a toxic gas prompting the licensee to declare an Alert. Later in the scenario, the licensee declared a site area emergency based upon the unit experiencing a main turbine trip; with an anticipated transient without SCRAM (ATWS) event. During the drill, the inspectors assessed the licensee's actions to verify that emergency classifications and notifications were made in accordance with licensee emergency plan implementing

procedures (EIPs) and 10 CFR 50.72 requirements. The inspectors specifically reviewed that the Alert and Site Area Emergency classifications and notifications were made in accordance with licensee procedures 0-EPIP-20101, "Duties of Emergency Coordinator," and 0-EPIP-20101, Attachment 1, "Hot Conditions Table." The inspectors also observed whether the initial activation of the emergency response centers was timely and as specified in the licensee's emergency plan. The inspectors attended the licensee's drill critique and verified the identified critique items and drill weaknesses were captured in the licensee's CAP. This inspection constitutes one sample.

b. Findings

No findings were identified.

4OA1 Performance Indicator Verification

.1 Mitigating Systems Cornerstone

a. Inspection Scope

The inspectors reviewed licensee submittals for the Unit 3 and Unit 4 performance indicators (PI) listed below for the period July 1, 2015, through June 30, 2016, to verify the accuracy of the PI data reported during that period. Performance indicator definitions and guidance contained in NEI 99-02, "Regulatory Assessment Performance Indicator Guideline," and licensee procedure 0-ADM-032, "NRC Performance Indicators Turkey Point," were used to check the reporting for each data element. The inspectors checked operator logs, plant status reports, condition reports, licensee event reports, system health reports, and PI data sheets to verify that the licensee had identified the required data, as applicable. The inspectors interviewed licensee personnel associated with performance indicator data collection, evaluation, and distribution. This inspection constitutes two samples.

- Unit 3 Safety System Functional Failures
- Unit 4 Safety System Functional Failures

b. Findings

No findings were identified.

4OA2 Problem Identification and Resolution

.1 Daily Review

a. Inspection Scope

As required by Inspection Procedure 71152, "Identification and Resolution of Problems," and to help identify repetitive equipment failures or specific human performance issues for follow-up, the inspectors performed a screening of items entered daily into the licensee's CAP. This review was accomplished by reviewing daily printed summaries of ARs and by reviewing the licensee's electronic AR database. Additionally, reactor coolant system (RCS) unidentified leakage was checked on a daily basis to verify no substantive or unexplained changes.

b. Findings

No findings were identified.

.2 Annual Sample

a. Inspection Scope

The inspectors selected the two action requests (ARs) listed below for a more in-depth review of the circumstances and the corrective actions that followed. The ARs were reviewed to ensure that appropriate evaluations were performed and corrective actions were specified and prioritized in accordance with the licensee's program. Other attributes checked included resolution of the problem including cause determination and corrective actions. The inspectors interviewed plant personnel and evaluated the condition report in accordance with the requirements of the licensee's corrective actions process as specified in licensee procedures PI-AA-104-1000, "Condition Reporting." This inspection constitutes two samples.

- AR 2155881, Lack of awareness of 10 CFR 50.70 requirements
- AR 2111601, Fifth 10-year IST Program Implementation

b. Findings

Introduction: The inspectors identified a Severity Level (SL) IV NCV of 10 CFR 50.70, "Inspections," paragraph (b)(4), for the licensee's failure to ensure that the arrival and presence of an NRC inspector was not communicated to persons at the facility.

Description: On September 14, during an unannounced deep backshift inspection, an NRC inspector approached a security bullet blast resistant enclosure (BBRE) and identified himself to the security officer that was stationed inside. The officer cracked open the BBRE access door and asked the the purpose for access to the BBRE. The inspector identified himself and relayed intent to complete an inspection inside the BBRE. The officer asked the inspector to wait, closed the access door, and called his lieutenant to inform him of the inspector's presence and request to access the BBRE. After a short period of time the lieutenant arrived at the BBRE location and asked the purpose for requesting access to the BBRE. The lieutenant then communicated to the officer in the BBRE to grant the NRC inspector access. While inside the BBRE the officer stated that his procedures require that he call the lieutenant anytime NRC requested access to the BBRE.

Upon exiting the BBRE the inspector then entered a nearby security ready room. Immediately after the inspector identified himself to the lieutenant at the front desk, the lieutenant hand signaled to the inspector, asked him to wait, and proceeded to call the central alarm station (CAS) captain. The lieutenant relayed to the captain that NRC had entered the room and was asking questions. The lieutenant informed the inspector that his procedures require him to call the captain anytime QA or NRC comes into the room.

Shortly thereafter the NRC inspector attempted to enter another BBRE station. The officer at the BBRE called the CAS captain to inform him of the inspector's presence and of his request to access the BBRE. Once inside the BBRE, the officer explained to the

inspector that his procedures require him to notify the captain anytime an NRC inspector requests access to the BBRE. The licensee entered this issue into the CAP as AR 2155881. Security management informed the inspectors that there are no procedures requiring security personnel to communicate NRC presence to the lieutenant or captain. Immediate corrective actions included training the officers at the security turn-over meetings on the 10 CFR 50.70 requirements, and a fleet-wide communication to the employees regarding the requirements of 10 CFR 50.70 to ensure all employees understood these requirements.

Analysis: The licensee's actions of announcing the presence and location of an NRC inspector during an unannounced inspection in the protected area was a performance deficiency. The NRC evaluated this issue under the traditional enforcement process with no associated Reactor Oversight Process (ROP) finding. Traditional enforcement violations are not assessed for cross-cutting aspects.

The act of announcing NRC presence could impact the NRC's ability to perform its regulatory function, specifically, the NRC relies on its ability to perform unannounced inspections to evaluate licensee performance. Communicating the presence and location of NRC inspectors affects their ability to perform these inspections, and as such the regulatory function is impacted. The finding was reviewed by NRC management and because the violation was determined to be of very low safety significance, was not repetitive or willful and was based solely upon a lack of understanding of the procedural and regulatory requirements, and was entered into the CAP, this violation is being treated as a Severity Level IV non-cited violation consistent with the NRC Enforcement Policy.

Enforcement: 10 CFR 50.70 (b)(4) requires, in part, that the licensee shall ensure that the arrival and presence of an NRC inspector, who has been properly authorized facility access, is not announced or otherwise communicated by its employees or contractors to other persons at the facility unless specifically requested by the NRC inspector. Contrary to this, on September 14, 2016, the licensee failed to ensure that the arrival and presence of an NRC inspector, who was properly authorized facility access, was not announced or otherwise communicated by its employees or contractors to other persons at the facility. Specifically, within a very short period of time at three different locations in the protected area, security officers at two BBREs and a ready room notified security supervision of the presence of an NRC inspector arriving at their duty station. There was no actual or potential security consequence. Immediate corrective actions were taken to ensure officers understood the regulatory requirements. Because the finding is of very low safety significance and has been entered into the licensee's CAP as AR 2155881, this violation is being treated as an NCV consistent with Section 2.3.2.a of the Enforcement Policy: NCV 05000250,251/2016003-02, "Communication of an NRC Inspector Presence by Security Personnel."

4OA3 Follow-up of Events and Notice of Enforcement Discretion

.1 (Closed) Licensee Event Report (LER) 05000250/2016-001-00 and -01, "Loose Breaker Control Power Fuse Caused 3B Emergency Containment Cooler to be Inoperable Longer Than Allowed"

a. Inspection Scope

On February 8, 2016, during a surveillance test the 3B Emergency Containment Cooler (ECC) fan tripped. Troubleshooting and subsequent investigation revealed that the control power fuse for the fan's power supply breaker was loose in its fuse holder and the fuse holder clips had been widened during work activities associated with the installation of the new breaker during the prior Unit 3 refueling outage. The licensee determined that the ECC was inoperable for approximately 72 days from November 28, 2015, until February 8, 2016, which exceeded the TS Required Action times of TS LCO 3.6.2.2.

The inspectors reviewed the LER, AR and Apparent Cause Evaluation Report to verify that the cause of the loose fuse was identified and that corrective actions were appropriate.

The inspectors also reviewed Revision 1 to this LER to verify that the appropriate reporting requirements had been met. The inspectors determined that the failure to initially identify all applicable reporting codes on the LER was a minor violation because it did not impact the completeness or accuracy of other information (e.g., performance indicator data) submitted to the NRC. This LER is closed.

b. Findings

Introduction: A self-revealed Green Non-cited Violation (NCV) of Technical Specification (TS) Limiting Condition for Operation (LCO) 3.6.2.2 was identified for the failure to properly insert the control power fuse for the 3B Emergency Containment Cooler (ECC) fan. The ECC unit was determined to be inoperable for greater than the allowed outage time of 72 hours and the actions required by TS LCO 3.6.2.2, Action A, were not taken.

Description: On February 8, 2016, during a surveillance test on Unit 3, control room indications identified that the 3B ECC fan tripped. Troubleshooting found that the control power fuse for the fan's power supply breaker was loose in its fuse holder and the fuse would easily spin inside its holder.

The licensee initiated AR 2108256 to investigate the cause and evaluate the condition. The licensee determined that the fuse holder clips had been widened during work activities associated with the installation of a new breaker for the 3B ECC fan during the prior Unit 3 refueling outage. The licensee determined the most probable cause of the loose fuse was improper insertion. In addition, the installation procedure did not validate fuse holder gap, fuse alignment, and fuse tightness after its last removal and insertion prior to placing the new breaker in service. Inadequate contact during the surveillance test caused the fan to trip.

The 3B ECC unit would not have reliably met its safety function mission time and so was determined to be inoperable for approximately 72 days, extending back to when Unit 3 entered Mode 4 on November 28, 2015. The 3B ECC unit had been inoperable longer than the 72 hours allowed by TS 3.6.2.2 LCO Condition A, and the resultant actions of the LCO were not taken. This made the issue reportable to the NRC in accordance with 10 CFR 50.73(a)(2)(i)(B) as a condition prohibited by TS. Licensee Event Report (LER) 05000250/2016-001-00 was submitted to the NRC on April 7, 2016. Additionally, there were several occasions where one of the other two ECCs were concurrently inoperable for testing during the 72-day period where the 3B ECC was inoperable. The longest

period during which two ECCs were concurrently inoperable was approximately 2.23 hours. During periods with two ECCs concurrently inoperable, the ECC system would not have been able to perform its specified safety function. During this inspection, the inspectors questioned the licensee regarding the reporting requirements for the loss of safety function. As a result, on August 15, 2016, the licensee issued a supplement to the LER (05000250/2016-001-01) indicating that the condition was also reportable in accordance with 10 CFR 50.73(a)(2)(v)(D).

An immediate corrective action was taken to adjust the fuse holder clips on the 3B ECC breaker to provide a tight fit. Additional corrective actions initiated by the licensee in AR 2108256 included a review of recently replaced similar breakers on Units 3 and 4 to identify and schedule inspection of fuse tightness. Future installations and preventative maintenance of similar breakers will check fuse tightness and correct if necessary.

Analysis: Failure to properly insert the control power fuse and verify fuse tightness was a performance deficiency. This failure rendered the 3B ECC fan inoperable for longer than allowed by TS. The inspectors determined that the finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of Equipment Performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the 3B ECC was not available to automatically start upon receipt of a safety injection signal, and during periods with two ECCs concurrently inoperable, the ECC system would not have been able to perform its specified safety function.

The inspectors evaluated the safety significance of the finding using IMC 0609, Attachment 4, "Initial Characterization of Findings," Table 2, under mitigation systems cornerstone, dated July 1, 2012, and IMC 0609 Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2 "Mitigating Systems Screening Questions." Because the finding represented a loss of system and/or function the finding required a detailed risk assessment. A Senior Reactor Analyst performed a bounding risk assessment by failing all three containment coolers in the Turkey Point SPAR model for the entire exposure time of 72 days. The dominant accident sequence was a very small loss of coolant accident (LOCA) where high head safety injection fails for independent reasons. The delta-CDF due to the performance deficiency was 1E-8. The low risk result was driven by the low frequency of LOCAs, the limited exposure time, and the low risk value of the containment coolers themselves. The finding was determined to be of very low safety significance (Green).

The inspectors reviewed this finding for cross-cutting aspects in accordance with IMC 0310, "Aspects Within the Cross-Cutting Areas." This finding was assigned a cross cutting aspect associated with the avoid complacency aspect of the human performance area because the licensee failed to confirm fuse holder tightness following implementation of breaker maintenance. The licensee failed to recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes (H.12).

Enforcement: Technical Specification (TS) Limiting Condition for Operation (LCO) 3.6.2.2 required that three ECC units shall be operable. With one of the required ECC units inoperable, Condition A of TS 3.6.2.2 LCO required that the inoperable ECC unit be restored to operable status within 72 hours or be in at least hot standby within the

next 6 hours and cold shutdown within the following 30 hours. Contrary to Condition A of TS 3.6.2.2 LCO, the 3B ECC unit was inoperable from November 28, 2015, until February 8, 2016, which exceeded the time limits of the LCO, and the required actions in Condition A were not taken. The licensee included this issue in their corrective action program as AR 2108256. Following discovery of the condition, the licensee took immediate corrective actions to adjust the fuse holder clips on the 3B ECC breaker to provide a tight fit. Because this violation was of very low safety significance and it was entered into the licensee's corrective action program, this violation is being treated as an NCV, consistent with Section 2.3.2.a of the NRC Enforcement Policy. (NCV 05000250/2016003-03, "Improper ECC Fuse Installation")

.2 Event Follow Up - Unit 3 Shutdown

a. Inspection Scope

On July 30th, at approximately 1:45 a.m., during execution of a Unit 3 clearance while isolating extraction steam to the 5B feedwater heater, field operators reported hearing continuous water hammer from the 5B heater and also reported that some pipes in the feedwater system were shaking. Control room annunciators locked in on high water level on the 5B heater. All work was stopped and several attempts from the control room to stop the water hammer were not successful. The unit entered the fast load reduction procedure and was manually tripped at 14% RTP (per procedure) and was placed in Mode 3 (hot standby). The inspectors responded to the Unit 3 control room after notification of the unit trip. The inspectors completed a control board walk down to verify the unit was in a stable state and that decay heat was being adequately removed. The inspector reviewed control room chronological logs, control room indications, post trip procedures, and interviewed control room operators to verify that operating restrictions and procedural requirements were met and to assess whether any equipment complications had been experienced immediately following the unit trip. The inspector reviewed documentation and operator actions associated with licensee emergency operating procedures which had been completed during the reactor trip. The inspectors attended the failure investigation review meetings and reactor trip review and start-up meetings. The unit was returned to 100% RTP on August 3, 2016.

b. Findings

No findings were identified

4OA5 Other Activities

.1 Independent Spent Fuel Storage Facility (ISFSI) Walk down (IP 60855.1)

a. Inspection Scope

On September 15, 2016, inspectors conducted a walk down of the ISFSI protected area per inspection procedure 60855.1, "Operation of an ISFSI at Operating Plants." The inspectors observed each cask building temperature indicator and passive ventilation system to be free of any obstruction allowing natural draft convection decay heat removal through the air inlet and air outlet openings. The inspectors observed

associated cask building roof and structures to be structurally intact and radiation protection access controls to the ISFSI area to be satisfactory.

b. Findings

No findings were identified.

4OA6 Meetings

The resident inspectors presented the inspection results to Mr. Summers and other members of licensee management on October 13, 2016. The inspectors asked the licensee whether any of the material examined during the inspection should be considered proprietary information. The licensee did not identify any proprietary information.

4OA7 Licensee-identified Violations

None.

ATTACHMENT: SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel:

C. Cashwell, Training Manager
B. Berryman, Plant General Manager
O. Hernandez, Security Manager
M. Guth, Licensing Manager
O. Hanek, Licensing Engineer
A. Katz, Projects Manager
G. Melin, Assistant Operations Manager
S. Mihalakea, Licensing Engineer
M. Downs, Emergency Preparedness Manager
K. O'Hare, Performance Improvement Manager
J. Pallin, Engineering Director
B. Stamp, Operations Director
T. Summers, Site Vice-President
R. Hess, General Operations Training Supervisor

NRC Personnel:

A. Wilson, Project Engineer
J. Patel, Senior Reactor Inspector
L. Pressley, Senior Project Engineer

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened and Closed

05000251/2016003-01	NCV	Failure to provide adequate flood protection for the 4A RHR train (Section 1R06)
05000250,251/2016003-02	NCV	Communication of an NRC Inspector Presence by Security Personnel (Section 4OA2)
05000250/2016003-03	NCV	Improper ECC Fuse Installation (Section 4OA3)

Closed

05000250/2016-001-00,-01	LER	Loose Breaker Control Power Fuse Caused 3B Emergency Containment Cooler to be Inoperable Longer Than Allowed (Section 4OA3)
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LIST OF DOCUMENTS REVIEWED

Section 1R01: Adverse Weather

0-EPIP-20106, Natural Emergencies

Section 1R04: Equipment Alignment

3-OSP-023.1, Diesel Generator Operability Test

4-OSP-023.1, Diesel Generator Operability Test – Attachment 6, System Flow path Verification

4-OSP-023.1, Diesel Generator Operability Test – Attachment 4, 4B EDG Standby Status

4-OSP-019.2, Intake Cooling Water System Flow path Verification

5614-M-3019, Unit 4 Intake Cooling Water System

3-OP-050, Residual Heat Removal System

5613-M-3050, Residual Heat Removal Systems

Section 1R05: Fire Protection

PFP-CB-30, Unit 3&4 Control Building

PFP-CB-42, Unit 3&4 Control Building

0-ONOP-016.10, Pre-Fire Plan Guidelines and Safe Shutdown Manual Actions

0-ADM-016.1, Transient Combustible and Flammable Substances Program

Section 1R06: Flood Protection Measures

Action Request 02155629, NRC Resident Identified Poor Housekeeping in the 4A RHR Pit

0-PMI-061.04, RHR Room Sumps Functional Test

Work Order 40391053, 4A RHR Room Sump, Alarms, and Pump Test

Work Order 40422253-02, Erect/Remove Work Scaffold

MA-AA-100-1008, Station Housekeeping and Material Control

Section 1R07: Heat Sink Performance

4-OSP-030.4, Component Cooling Water Heat Exchanger Performance Test

Section 1R11: Licensed Operator Regualification Process

0-ADM-211, Emergency and Off-Normal Operating Procedure Usage

TR-AA-230-1007, Conduct of Simulator Training and Evaluation

Section 1R12: Maintenance Effectiveness

Action Request 02108256, 3B ECC Fan Tripped

Action Request 02095631, B SSGFP Failed to Start for OSP

Action Request 02073396, SSGFP Failed to Start

Section 1R15: Operability Evaluations

Action Request 02139372, 4A EDG Radiator Fan Spinning Slow At First

Action Request 01732759, Deficiencies Identified with the CRVS Backdraft Damper D-19

Technical Specification 3/4.7.5, Control Room Emergency Ventilation System

0-ADM-536, Technical Specification Bases Control Program

0-ADM-213, Technical Specification Related Equipment Out of Service Logbook

EN-AA-203-1001, Operability Determinations/Functionality Assessments

Section 1R18: Plant Modifications

Action Request 01823257, Replace Isolation Dampers D-19 and D-23 for CREVs

Action Request 01812483, Operations Concern for Long Term Resolution

Engineering Change 249140, CREVS Compensatory Filter Train Addition
 Drawing 5610-M-3025, Control Building Ventilation
 Drawing 5610-M-87, Control Building Elevation 30'
 Drawing 5610-M-86, Control Building Elevation 42'
 Drawing 5610-M-85, Elevation 30' & 42' HVAC

Section 1R19: Post Maintenance Testing

Turkey Point UFSAR, Section 9.15.2, "Emergency Diesel Generator Cooling Water System"
 0-GMP-102.3, Agastat Time Delay Relay Calibration
 0-ADM-016, Fire Protection Program
 0-OSP-016.26, Electric Driven Fire Pump Operability Test
 P&ID 5610-M-3016, Fire Protection System – Units 1 thru 4 – Fire Pumps
 Clearance 0-016-EDFP(P39) Quarterly PM – 014
 0-PMM-019.7, Intake Cooling Water Basket Strainer Cleaning and Inspection

Section 1R22: Surveillance Testing

3-OSP-023.1, Diesel Generator Operability Test
 Work Order 40412960, 3A EDG Operability Test (Normal Start)
 4-OSP-023.2, Diesel Generator 24 Hour Full Load Test and Load Rejection
 4-OSP-068.5A, 4A Containment Spray Pump Comprehensive In-service Test
 P&ID 5614-M-3068, Containment Spray System
 American Society of Mechanical Engineers, Code for Operation and Maintenance of Nuclear Power Plants, 2004 edition
 L-2016-139, Turkey Point Nuclear Plant Units 3 and 4: In-service Testing Program Plan for the Fifth Ten Year Interval
 Action Request 02086743, 0-ADM-502 Not Updated to Reflect Current Code Being Used
 Action Request 02112454, Ineffective Implementation of the Turkey Point IST Program
 Action Request 02134739, Batch PCR – Update ASME OM Code Reference
 Action Request 02131635, 3/4-OSP-058.5A & 5B – 3A CS Pump Comprehensive IST
 Action Request 02131638, 3/4-OSP-068.2 – Containment Spray System Testing
 Work Order 40425213 01, MOV-6459C MOV INSP/GR INSP/STROKE
 0-OSP-074.3, Standby Steam Generator Feed water Pumps Availability Test

Section 1EP6: Drill Evaluation

FP&L Turkey Point Emergency Preparedness Quarterly Drill, September 20, 2016

Section 4OA3: Follow-up of Events and Notices of Enforcement Discretion

LER 05000250/2016-001-00 and -01, Loose Breaker Control Power Fuse Caused 3B Emergency Containment Cooler to be Inoperable Longer than Allowed
 Action Request 02108256, 3B ECC Fan Tripped During 3-OSP-055.1

LIST OF ACRONYMS

AFW	Auxiliary Feed water
AR	Action Request
ASME	American Society of Mechanical Engineers
CAP	Corrective Action Program
CCW	Component Cooling Water
CFR	Code of Federal Regulations
EDG	Emergency Diesel Generator
FME	Foreign Material Exclusion
GOP	General Operating Procedure
HHSI	High Head Safety Injection
ICW	Intake Cooling Water
IST	In-service Testing
LCO	Limiting Condition of Operation
LER	Licensee Event Report
NAP	Nuclear Administrative Procedure
NRC	Nuclear Regulatory Commission
OCC	Outage Control Center
ONOP	Off Normal Operating Procedure
OOS	Out of Service
OSP	Operations Surveillance Procedure
P&ID	Piping and Instrumentation Drawing
PI	Performance Indicator
PW	Primary Water
RCE	Root Cause Evaluation
RCP	Reactor Coolant Pump
RCS	Reactor Coolant System
RHR	Residual Heat Removal
RTP	Rated Thermal Power
SI	Safety Injection
TS	Technical Specifications
U3	Unit 3
U4	Unit 4
UFSAR	Updated Final Safety Analysis Report
WO	Work Order