UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30323

Report Nos.: 50-250/91-16 and 50-251/91-16

Licensee: Florida Power and Light Company
9250 West Flagler Street
Miami, FL 33102

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

Facility Name: Turkey Point Units 3 and 4

Inspection Conducted: April 27 through May 24, 1991

Inspectors: _____ 6/10/91
R. C. Butcher, Senior Resident Inspector Date Signed

_____ 6/10/91
G. A. Schnebli, Resident Inspector Date Signed

_____ 6/10/91
L. Trocine, Resident Inspector Date Signed

Approved by: _____ 6/10/91
R. V. Crlenjak, Chief Date Signed
Reactor Projects Section 2B
Division of Reactor Projects

SUMMARY

Scope:

This routine resident inspector inspection entailed direct inspection at the site in the areas of monthly surveillance observations, monthly maintenance observations, operational safety, and plant events.

Results:

Within the scope of this inspection, the inspectors determined that the licensee continued to demonstrate satisfactory performance to ensure safe plant operations. One unresolved item was identified. Violations or deviations were not identified.

Unresolved Item** 50-250,251/91-16-01. Determine cause for wiring errors in the 4B Emergency Diesel Generator output breaker position circuitry (paragraph 6).

** Unresolved Items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

T. V. Abbatiello, Quality Assurance Supervisor
*J. Arias, Jr., Technical Assistant to Vice President
*L. W. Bladow, Quality Manager
*W. D. Brown, Site Construction Manager
*T. A. Finn, Assistant Operations Superintendent
R. J. Gianfrencesco, Assistant Maintenance Superintendent
*S. T. Hale, Engineering Project Manager
K. N. Harris, Senior Vice President - Nuclear Operations
E. F. Hayes, Instrumentation and Controls Supervisor
R. G. Heisterman, Assistant Superintendent of Electrical Maintenance
*V. A. Kaminskas, Operations Superintendent
*J. E. Knorr, Regulatory Compliance Supervisor
J. A. Labarraque, Senior Technical Advisor
G. L. Marsh, Reactor Supervisor
H. Johnson, Operations Supervisor
L. W. Pearce, Plant Manager - Nuclear
*T. F. Plunkett, Site Vice President
D. R. Powell, Superintendent - Plant Licensing
K. L. Remington, System Performance Supervisor
C. V. Rossi, Quality Assurance Supervisor
*G. M. Smith, Service Manager - Nuclear
R. N. Steinke, Chemistry Supervisor
J. C. Strong, Mechanical Department Supervisor
F. R. Timmons, Site Security Superintendent
M. B. Wayland, Maintenance Superintendent
J. D. Webb, Assistant Superintendent Planning and Scheduling
A. T. Zielonka, Technical Department Supervisor

Other licensee employees contacted included construction craftsman, engineers, technicians, operators, mechanics, and electricians.

NRC Resident Inspectors

*R. C. Butcher, Senior Resident Inspector
G. A. Schnebli, Resident Inspector
*L. Trocine, Resident Inspector

* Attended exit interview on May 24, 1991

Note: An alphabetical tabulation of acronyms used in this report is listed in the last paragraph in this report.

2. Plant Status

- The 4A EDG modifications remain on schedule with preparations in progress for initial engine run from the control room. Phase II preoperational testing is scheduled for early June.

- The 4B EDG successfully completed Phase II preoperational testing and is being turned over to operations.

- Wiring modifications and terminations are in progress on the 3A and 4A sequencers. Prerequisite testing is in progress on the 3B and 4B sequencers.

- The DC bus outages continue on schedule with the 3B DC bus preoperational testing scheduled for late this month.

- The 3B and 4B 4160-volt bus outages were completed last month. The 3A and 4A 4160-volt busses were returned to service May 22 and 23, 1991, respectively.

- The 4-KV/480-volt switchgear room HVAC modifications are on schedule. The A train prerequisite testing is in progress on both units. The B train on both units is near completion.

- The control room air conditioning modifications are on schedule with two units operating. The last unit is to be turned over to startup the last of this month.

- The security system upgrade continues with the overall project approximately 88% complete. All cameras required for vitalization are operational at the CAS/SAS. The intrusion detection systems required for vitalization are also operational at the CAS/SAS. Vitalization of new security system areas is scheduled for July 1, 1991.

- The new RTD system installation continues with cable termination and Eagle 21 work in the control room in progress.

- The new ATWS panels are installed with conduit and wiring installation in progress.

- Inspection and repair of the ICW intake structure has been completed for this outage.

- The Unit 3 and 4 A ICW header inspection/repair is on schedule.

- The 3A and 3B EDG upgrade modifications are in progress. The 3B EDG is scheduled to start preoperational testing late this month. The 3A EDG initial engine run is scheduled for early June.

- The new ARMs system installation is complete. Prerequisite testing is in progress.

- The Unit 4 steam generator eddy current testing was completed. Only one tube required plugging as a result of eddy current testing.

- W continued work on the Unit 3 high pressure turbine casing erosion repair.

3. Followup on Items of Noncompliance (92702)

A review was conducted of the following noncompliance to assure that corrective actions were adequately implemented and resulted in conformance with regulatory requirements. Verification of corrective action was achieved through record reviews, observation, and discussions with licensee personnel. Licensee correspondence was evaluated to ensure the response was timely and corrective actions were implemented within the time periods specified in the reply.

(Closed) VIO 50-250,251/91-05-01; Failure to follow QI 3-PTN-1 in that a design change reflected in PC/M 88-503 was not adequately incorporated into procedure 0-OSP-016.30.

This violation involved a failure to follow procedure QI 3-PTN-1, Design Control, in that a design change involving the addition of fire header piping as reflected in PC/M 88-503 was not adequately incorporated into procedure 0-OSP-016.30, Annual Fire Main Post Indicator Valve (PIV) Leak Test and System Flush. This resulted in the inability to isolate and leak test a portion of the fire header piping during the performance of Sections 7.1.15 and 7.1.16 of procedure 0-OSP-016.30 on January 18, 1991. The licensee's March 29, 1991, response to this violation was reviewed by the inspectors. The responsible fire protection member was counselled, and procedure 0-OSP-016.30 was revised to incorporate the addition of the fire loop installed by PC/M 88-503. This was accomplished by January 19, 1991. Corrective actions to prevent recurrence involved the development of department instructions by the Nuclear Services Department for applicable groups in the department. The instructions provide guidance and a checklist to ensure that department related PC/Ms are properly reviewed by the group and incorporated if necessary into their procedures. This was accomplished by April 29, 1991. Corrective actions for this violation were deemed to be adequate, and this violation is considered to be closed.

4. Followup on Inspector Followup Items (92701)

Actions taken by the licensee on the item listed below were verified by the inspector.

(Closed) IFI 50-250,251/90-04-04; Followup Investigation of Unit 3 SFP Pump Shaft Failure.

This issue was previously discussed in IR 50-250,251/90-04 and in LER 50-250/90-003. The licensee provided supplemental information in LER 50-250/90-003-01 dated September 14, 1990, which contained the root

cause analysis of the failure and provided additional corrective actions deemed necessary. The inspectors reviewed the supplemental LER and consider the analysis and corrective actions to be adequate. This IFI is closed.

5. Onsite Followup and In-Office Review of Written Reports of Nonroutine Events and 10 CFR Part 21 Reviews (90712/90713/92700)

The Licensee Event Reports and/or 10 CFR Part 21 Reports discussed below were reviewed. The inspectors verified that reporting requirements had been met, root cause analysis was performed, corrective actions appeared appropriate, and generic applicability had been considered. Additionally, the inspectors verified the licensee had reviewed each event, corrective actions were implemented, responsibility for corrective actions not fully completed was clearly assigned, safety questions had been evaluated and resolved, and violations of regulations or TS conditions had been identified. When applicable, the criteria of 10 CFR Part 2, Appendix C, were applied.

a. (Closed) P21 50-250,251/90-04; Rosemount Resistance Bridges Exhibit Premature Long-Term Degradation Under Certain Combinations of Humidity, Power, and Duration.

The licensee received two letters from Rosemount dated April 23 and 25, 1991, stating that FPL was not affected by this issue and that Rosemount showed no record of shipping any of the affected parts to FPL plants. This P21 is closed.

b. (Closed) LER 50-250/90-15; Roving Fire Watch Failed to Complete TS Required Rounds Due to Personnel Error.

The inspectors reviewed the corrective actions required by this LER and found them to be adequate. This LER is closed.

c. (Closed) LER 50-250/90-16; TS 3.0.1 Entered to Repair Boric Acid Filter Discharge Isolation Valve 3-348.

The inspectors reviewed the corrective actions required by this LER and found them to be adequate. This LER is closed.

d. (Closed) LER 50-250/90-20; Missed TS Required Surveillance on Station Batteries Due to Personnel Error.

This LER was previously discussed in IR 50-250,251/90-36 and was identified as NCV 50-250,251/90-36-02. This LER is closed.

6. Monthly Surveillance Observations (61726)

The inspectors observed TS required surveillance testing and verified that the test procedure conformed to the requirements of the TSs; testing was performed in accordance with adequate procedures; test instrumentation was

calibrated; limiting conditions for operation were met; test results met acceptance criteria requirements and were reviewed by personnel other than the individual directing the test; deficiencies were identified, as appropriate, and were properly reviewed and resolved by management personnel; and system restoration was adequate. For completed tests, the inspectors verified testing frequencies were met and tests were performed by qualified individuals.

The inspectors witnessed/reviewed portions of the following test activities:

a. O-OSP-016.1, Electric Driven Fire Pump Annual Surveillance Test;

b. POP-0804.099, Emergency Diesel Generator 4B System Preoperational Test Phase II (35 starts);

c. O-SMM-016.8, Main/Auxiliary Transformer and Hydrogen Seal Oil Unit Fire Suppression System Functional Test (for Unit 4);

d. TP-646, GM Portable Diesel Generator (loaded test); and

e. AP 0190.90, ASME Section XI Pressure Tests for Quality Group A, B, and C Systems/Components (Test No. 04-30310-01 for the Unit 4 CCW surge tank). (Refer to paragraph 9.b of this report for additional information.)

During performance of the third preoperational test for the 35 consecutive starts of the 4B EDG on May 9, 1991, the 4B EDG day tank auto fill system failed to operate, and testing was terminated. Previously, IR 50-250,251/90-42 addressed an inadequate M-K relay design for the Unit 4 EDG solenoid valve for fuel isolation to the day tank. The failure of relay FOT to control EDG fuel isolation solenoid valve SV-3434B occurred near the end of the 4B EDG 24-hour endurance run. This was identified as URI 50-250,251/90-42-03. IR 50-250,251/91-03 closed URI 50-250,251/90-42-03 and discussed a design change replacing the existing FOT relay with a relay of higher rating.

Investigation of the latest failure of the Unit 4 EDG day tank fuel oil transfer system showed that a blown fuse, a shorted diode, and isolation relay FTC all failed. The licensee believes the failures could have been caused by a random failure of the diode. In addition, engineering concluded that the revised larger relay, FOT, resulted in relay FTC being underrated for its current application. A design change was initiated to reinstall the original relay in the original circuit and add a second circuit with a slave relay of larger capacity to operate the fuel transfer system isolation solenoid. A test program was conducted to verify the day tank fuel oil transfer system. Following operability testing of only the fuel oil transfer system circuitry, the 4B EDG was started locally three times to further verify the engineering fix. At 12:17 a.m. on May 14, 1991, preoperational testing of the 35 starts on the 4B EDG recommenced.

On May 18, 1991, the licensee completed run No. 33 of 35 for the 4B EDG in accordance with POP 0804.099, Emergency Diesel Generator 4B System Preoperational Test Phase II. The 4B EDG was in the cooldown cycle running at 450 RPM with the output breaker open per step 9.6.12.1 of the procedure. The EDG is to remain in this mode for approximately 20 minutes and then automatically stop. However, prior to the completion of the 20-minute cooldown, the EDG tripped and several alarms were observed at the control panel. TER No. 12 was initiated documenting the premature trip, and a JTG meeting was conducted to determine if the test was valid per RG 1.108. The JTG concluded that reliability start No. 33 was a valid successful test per step C.2.e.(3) of the RG which states, "Successful starts, including those initiated by bona fide signals, followed by successful loading (sequential or manual) to at least 50% of continuous rating and continued operation for at least one hour should be considered valid successful tests." The inspectors were informed of the licensee's decision in this issue and concurred with this conclusion.

The licensee's initial investigation determined that the cause of the 4B EDG trip during the cooldown period was the installation of a test jumper across TB1-86 and TB1-88 in panel 3C12B. This jumper was installed for troubleshooting of the 3B EDG control circuitry. In the original design (two EDGs), the breaker position switch contact (8-8T) for breakers 3AB20 and 4AB21 (the output breakers from the original B EDG to the 3B and 4B 4160-volt busses) were connected in parallel to TB1-86 and TB1-88 in the B EDG lockout circuit via cables 4E35/A and 4E35/C, respectively. For the new design (four EDGs), cable 4E35/C was to be de-terminated and spared and cable 4E35/A was to be relabeled as DG3B/3AB20-3C12B/Y. Thus, the original B EDG was separated from the 4B 4160-volt bus. The implementation of these design modifications resulted in cable 4E35/A being spared, and cable 4E35/C being retagged and left terminated on both the 4AB21 and 3C12B ends, which is opposite from the new design. When the jumper was installed across TB1-86 and TB1-88 in 3C12B for troubleshooting 3B EDG control circuitry, it resulted in a short across breaker position switch contact 8-8T which simulated closure of the 4AB21 breaker (4B EDG output breaker). This caused an abnormal EDG logic condition in that the logic controls received a generator output breaker closed signal with the EDG idling at 450 RPM and the generator off. This abnormal condition caused relay 152 GX to be energized, which in turn de-energized the 20-minute cooldown timer circuit, and caused termination of engine idle via a signal to the governor to go to minimum fuel. Energization of the 152 GX relay also provided a permissive signal for the non-essential protective relay trips which should be initiated with a no voltage/engine run condition. As the engine was coasting to a stop, one of these protective relays (low water pressure at idle, low piston cooling oil pressure, or low main lube oil pressure) caused actuation of the shutdown relay which in turn tripped the lockout relay for the unit.

The licensee is currently conducting an investigation to determine the root cause for the wiring error and to identify other areas for verification that this problem does not exist elsewhere. This is identified as URI 50-250,251/91-16-01.

The inspectors determined that the above testing activities were performed in a satisfactory manner and met the requirements of the technical specifications. Violations or deviations were not identified.

7. Monthly Maintenance Observations (62703)

Station maintenance activities of safety-related systems and components were observed and reviewed to ascertain they were conducted in accordance with approved procedures, regulatory guides, industry codes and standards, and in conformance with the TSs.

The following items were considered during this review, as appropriate: LCOs were met while components or systems were removed from service; approvals were obtained prior to initiating work; activities were accomplished using approved procedures and were inspected as applicable; procedures used were adequate to control the activity; troubleshooting activities were controlled and repair records accurately reflected the maintenance performed; functional testing and/or calibrations were performed prior to returning components or systems to service; QC records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were properly implemented; QC hold points were established and observed where required; fire prevention controls were implemented; outside contractor force activities were controlled in accordance with the approved QA program; and housekeeping was actively pursued.

The inspectors witnessed/reviewed portions of the following maintenance activities in progress:

a. removal of the "T" between ICW valves 3-50-309, 310, and 312 and of the elbows associated with valve 3-50-312 to provide for the installation of a blind flange at ICW crossconnect valve 3-50-309 (For additional information, refer to paragraph 9.a of this report.);

b. replacement of 4C ICW pump discharge flange;

c. turbocharger and air start modifications to the 3A EDG;

d. continued troubleshooting of the 3C RCP seal failure; and

e. troubleshooting and replacement of No. 4 and 5 blackstart diesel generator immersion header controller.

For those maintenance activities observed, the inspectors determined that the activities were conducted in a satisfactory manner and that the work was properly performed in accordance with approved maintenance work orders. Violations or deviations were not identified.

8. Operational Safety Verification (71707)

The inspectors observed control room operations, reviewed applicable logs, conducted discussions with control room operators, observed shift turnovers, and monitored instrumentation. The inspectors verified proper valve/switch alignment of selected systems, verified maintenance work orders had been submitted as required, and verified followup and prioritization of work was accomplished. The inspectors reviewed tagout records, verified compliance with TS LCOs, and verified the return to service of affected components.

By observation and direct interviews, verification was made that the physical security plan was being implemented. The implementation of radiological controls and plant housekeeping/cleanliness conditions were also observed.

Tours of the intake structure and diesel, auxiliary, control, and turbine buildings were conducted to observe plant equipment conditions including potential fire hazards, fluid leaks, and excessive vibrations. In addition, the inspectors walked down accessible portions of systems which are currently required to be operable/functional in order to verify proper valve/switch alignment.

The licensee conducted a safety evaluation to define control of the plant configuration during the dual unit emergency power system enhancement project. Procedure TP-645, Defueled Operations Without Emergency Diesel Generators, was issued to proceduralize the requirements determined in the safety evaluation to be in effect from the time both units enter the defueled condition and both EDGs are removed from service. Also, portions of the revised TSs became effective when both units entered the defueled condition.

The licensee routinely performs QA/QC audits/surveillances of activities required under its QA program and as requested by management. To access the effectiveness of these licensee audits, the inspectors examined the status, scope, and findings of the following audit reports:

Audit Number	Number of Findings	Type of Audit
QAO-PTN-91-003	-	Vendor Visual Examination and Functional Testing of Snubbers
QAO-PTN-91-012	1	TS 3/4.6, Containment Systems
QAO-PTN-91-017	-	QP 11.4, Test Control, and QP 14.3, Inspection Test and Operating Status During Plant Operations
QAO-PTN-91-020	-	TS 3/4.3 Instrumentation
QAO-PTN-91-021	-	W MCC Faulty Wire Harness Replacement
QAO-PTN-91-023	-	Plant Nuclear Safety Committee
QAO-PTN-91-025	4	April Performance Monitoring Audit

The QA audit reports reviewed were distributed to the appropriate departmental managers, the Plant Manager, the CNRB, and the President - Nuclear Division. The applicable criteria, a description of the particular finding, a discussion of the issues, a statement of the impact on quality, a list of recommended corrective actions, a recommended responsible department, and the responsible QA contact were documented for each finding. In accordance with the licensee's QA program, the responsible department is required to respond to all QA findings in writing. No additional NRC followup actions will be taken on these findings because they were identified by the licensee's QA program audits, appropriate corrective actions have either been completed or are currently underway, and plant management has been made aware of these issues.

As a result of routine plant tours and various operational observations, the inspectors determined that the general plant and system material conditions were satisfactorily maintained, plant security program was effective, and that the overall performance of plant operations was good. In addition, the inspectors verified the critical electrical system lineup and verified the availability of the required number of blackstart diesel generators. Availability of the minimum number of ICW and CCW pumps was also verified. Violations or deviations were not identified.

9. Plant Events (93702)

The following plant events were reviewed to determine facility status and the need for further followup action. Plant parameters were evaluated during transient response. The significance of the event was evaluated along with the performance of the appropriate safety systems and the actions taken by the licensee. The inspectors verified that required notifications were made to the NRC. Evaluations were performed relative to the need for additional NRC response to the event. Additionally, the following issues were examined, as appropriate: details regarding the cause of the event; event chronology; safety system performance; licensee compliance with approved procedures; radiological consequences, if any; and proposed corrective actions.

a. On May 7, 1991, the "T" between ICW valves 3-50-309, 310, and 312 and the elbows associated with valve 3-50-312 was removed by construction in order to facilitate the installation of a blind flange on the side of ICW crossconnect valve 3-50-309 from which the "T" was removed. Because both the ICW system, which provides cooling for the CCW heat exchangers, and the CCW system, which in turn provides cooling for the SFP heat exchanger, would not be available during this evolution; it was necessary to temporarily secure SFP cooling. The operating SFP cooling, ICW, and CCW pumps were secured at 8:45 a.m., 8:50 a.m., and 8:52 a.m., respectively. These pumps were restored to service in reverse order at 11:55 a.m., 12:10 p.m., and 12:30 p.m. on the same day. While cooling was secured, the temperature in the Unit 3 SFP increased from 91 degrees F to 97 degrees F. (For additional information, refer to paragraph 7.a of this report.)

b. On May 8, 1991, the licensee performed the 10-year ISI hydrostatic test of the Unit 4 CCW surge tank. The test was conducted in accordance with AP 0190.90, Test No. 04-30310-01, which meets the requirements of ASME Section XI, 1980 Edition, Winter 1981 Addenda. The inspectors reviewed the procedure prior to performance and attended both pre-shift and pre-evolution briefings. The performance of this test required the temporary securing of the cooling for the Unit 4 SFP because the CCW system, which cools the SFP heat exchanger, would not be available during the test. The ICW system, which cools the CCW heat exchangers, was also secured during this test. SFP cooling was secured at 9:35 a.m. and was re-established at 1:15 p.m. at the completion of the hydrostatic test. While cooling was secured, the temperature in the Unit 4 SFP increased from 94 degrees F to 100 degrees F. The inspectors witnessed the test and verified that the test was completed satisfactorily. (For additional information, refer to paragraph 6.e of this report.)

c. On May 9, 1991, the licensee found a mechanical plug in the 4B steam generator that appeared to be leaking. The plug in the hot leg for tube R31-C14 had visible boric acid deposits on the plug end and inside the bore of the plug. An NCR (N91-0560) was generated requesting engineering evaluation. There are 22 tubes plugged (44 mechanical plugs) in Unit 4 with tubes manufactured from the same heat. The plugs were manufactured by W and are made of Inconel 600 material. The suspect plug was sent to W for evaluation, and no indications of plug cracking were found. The licensee concluded that the leak was probably due to the installation. The affected tube was plugged with a new plug.

d. At 12:55 p.m. on May 24, 1991, all five blackstart diesel generators were taken out of service for the enhancement of the back-up power supply to the battery charger per PC/M 90-338, Power for Blackstart Diesel Generators' Battery Charger (REA TPN-90-427). This modification involved the installation of a transfer switch to provide a method for the automatic transfer to an alternate source of power on loss of normal power. A transformer was also installed to step the voltage up from 208 to 240 volts in order to eliminate the need to re-adjust the internal settings of the battery charger, which is rated for a 240-volt input. Prior to this evolution, the inspectors reviewed the PC/M and associated drawings and were briefed by cognizant plant personnel. The installation of this modification and the associated startup testing were also witnessed by the inspectors. All of the blackstart diesel generators were returned to service at 1:15 p.m. on the same day.

Violations or deviations were not identified.

10. Preparation For Refueling (60705)

On May 23 and 24, 1991, the first new fuel assemblies for the Unit 4 refueling were off-loaded into the new fuel room. The inspectors

witnessed the transfer of new fuel from the fuel transfer cask to the new fuel room. Quality Control, Health Physics, and Security coverage was present during the off-loading process. The licensee used Operating Procedure 16009.2, On-Site Removal of New Fuel Assemblies From Shipping Containers and Handling of Shipping Containers, for the evolutions. The PSN controlled the evolution. Reactor Engineering performed an inspection of the container and fuel once the top was removed and recorded the results per the referenced procedure. The recorded data was then compared to the shipping data for agreement. All evolutions were coordinated and handled well. Violations or deviations were not identified.

11. Exit Interview (30703)

The inspection scope and findings were summarized during management interviews held throughout the reporting period with the Plant Manager - Nuclear and selected members of his staff. An exit meeting was conducted on May 24, 1991. The areas requiring management attention were reviewed. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection. Dissenting comments were not received from the licensee. Violations or deviations were not identified. The inspectors had the following finding:

Item Number	Description and Reference
URI 50-250,251/91-16-01	Determine cause for wiring errors in the 4B Emergency Diesel Generator output breaker position circuitry (paragraph 6).

12. Acronyms and Abbreviations

a.m.	ante meridiem
AP	Administrative Procedure
ARM	Area Radiation Monitor
ASME	American Society of Mechanical Engineers
ATWS	Anticipated Transient Without Scram
CAS	Central Alarm Station
CCW	Component Cooling Water
CFR	Code of Federal Regulations
CNRB	Company Nuclear Review Board
DC	Direct Current
EDG	Emergency Diesel Generator
F	Fahrenheit
FPL	Florida Power & Light
GM	General Motors
HVAC	Heating, Ventilation, and Air Conditioning
ICW	Intake Cooling Water
IFI	Inspector Followup Item
IR	Inspection Report
ISI	Inservice Inspection

JTG	Joint Test Group
KV	Kilovolt
LCO	Limiting Condition for Operation
LER	Licensee Event Report
MCC	Motor Control Center
M-K	Morrison-Knudson Company, Power Systems Division
NCR	Non-conformance Report
NCV	Non-cited Violation
NRC	Nuclear Regulatory Commission
OSP	Operations Surveillance Procedure
P21	10 CFR Part 21
PC/M	Plant Change/Modification
PIV	Post Indicator Valve
p.m.	post meridiem
POP	Preoperational Procedure
PSN	Plant Supervisor Nuclear
PTN	Plant Turkey Nuclear
QA	Quality Assurance
QAO	Quality Assurance Organization
QC	Quality Control
QI	Quality Instruction
QP	Quality Procedure
RCP	Reactor Coolant Pump
REA	Request for Engineering Assistance
RG	Regulatory Guide
RPM	Revolutions per Minute
RTD	Resistance Temperature Detector
SAS	Secondary Alarm Station
SFP	Spent Fuel Pit
SMM	Surveillance Mechanical Maintenance
SV	Solenoid Valve
TER	Test Exception Report
TP	Temporary Procedure
TPN	Turkey Point Nuclear
TS	Technical Specification
URI	Unresolved Item
VIO	Violation
W	Westinghouse