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U. S. NUCLEAR REGULATORY COMMISSION  
REGION I

Report No. 50-293/83-24

Docket No. 50-293

License No. DPR-35

Priority --

Category C

Licensee: Boston Edison Company

800 Boylston Street

Boston, Massachusetts 02199

Facility Name: Pilgrim Nuclear Power Station

Inspection At: Plymouth, Massachusetts

Inspection Conducted: November 8, 1983 - December 31, 1983

Inspectors:

Jon R. Johnson

J. Johnson, Senior Resident Inspector

Martin McBride

M. McBride, Resident Inspector

R.W. Borchardt

R. Borchardt, Reactor Engineer

Approved by:

Robert M. Gallo

R. Gallo, Chief, Reactor Projects Section  
No. 2A, Projects Branch No. 2

2/1/84  
date

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Inspection Summary:

Inspection on November 8, 1983 - December 31, 1983 (Report No. 50-293/83-24).

Areas Inspected: Routine unannounced safety inspection of plant operations including followup of previous findings, an operational safety verification, followup on events, trips, and LER's, a review of surveillance and maintenance activities, a review of refueling activities and outage preparations, a review of actions in response to the Performance Improvement Program, and a review of cold weather preparations. The inspection involved 163 inspector-hours by two resident inspectors and one reactor engineer.

Results: One violation was identified (Failure to log temperatures during a reactor vessel cooldown, Paragraph 2). Two licensee-identified violations are also described (Failure to implement T.S. surveillance requirements (LER 83-57), and Failure to implement T.S. requirements for water supplies with the torus drained (LER 83-64), both in Paragraph 4).

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## DETAILS

### 1. Persons Contacted

N. Brosee, Chief Maintenance Engineer  
W. Deacon, PIP Program Manager  
B. Eldredge, Sr. HP Supervisor  
R. Fairbank, Fluid Systems Group Leader  
E. Graham, Compliance Management Group Leader  
W. Hoey, Senior Radiation Protection Engineer  
P. Mastrangelo, Chief Operating Engineer  
C. Mathis, Station Manager  
J. Nicholson, Staff Assistant to Station Manager  
L. Oxsen, Director of Nuclear Operations  
P. Smith, Chief Technical Engineer  
K. Taylor, Day Watch Engineer  
A. Trudeau, Chief Radiological Engineer  
E. Ziemianski, Nuclear Operations Support Department Manager

The inspector also interviewed other members of the health physics, operations, maintenance, security, and technical staffs.

### 2. Followup on Previous Inspection Findings

- A. (Open) Unresolved Item (80-18-04). Review Actions for protecting rooms with concrete blocks from overpressure. On November 16, 1983, a licensee representative met with the inspector to discuss Nuclear Engineering Department (NED) memo 80-839, dated August 22, 1980. This memo states that it is NED's understanding that the required modifications to the applicable doors were implemented and that NED would place all these doors on the Q-List to insure configuration control. The licensee was again unable to provide documentation that the required doors were appropriately modified and stated that additional review would be performed. This item remains open.
- B. (Closed) Violation (82-19-04). A design requirement was not correctly translated into construction or as-built drawings. The licensee's response dated September 15, 1982 describes corrective actions which included 1) correcting the affected drawings, and 2) revising engineering department administrative controls to address "locked" designators. The inspector verified that Piping and Instrumentation Drawing M245, Rev. E4, contains the proper design requirement and "locked closed" designation. This item is closed.

- C. (Closed) Violation (82-19-05). Procedure No. 2.2.22 was revised and resulted in changing the torus dewatering valve (1301-80) from a locked closed to closed position without an adequate safety evaluation. The licensee's response dated September 15, 1982 states that the position change was most likely an administrative error and that a memo was issued re-emphasizing attention to detail. The licensee also stated that a Procedure Change Notice (PCN) would be issued to change the position back to locked closed. The inspector verified that a PCN was issued and Procedure 2.2.22 was changed (Rev. 15) to require the valve be locked closed. However, on November 8, 1983, the current revision (Rev. 17 dated January 1, 1983) had again deleted the requirement to lock the torus dewatering valve. The licensee's Nuclear Operations Support Manager stated that this was probably caused by one revision being hand typed and not getting into the word processing memory for which a future change was made. Following discussions with the inspector the licensee corrected this error. Revision 18 to procedure 2.2.22 correctly specifies the normal position of valve 1301-80 as "locked closed". This item is closed.
- D. (Open) Inspector Follow Item (83-03-11). Review status of evaluations and/or provide updated Licensee Event Reports. Out of the 36 "open" LER's that the inspector had questioned, the licensee has completed action on 13. On November 16, 1983, a licensee representative met with the inspector and described the status of long term corrective actions associated with LER No. 82-19. The licensee has approved, and issued for construction, a plant design change (No. 82-27) to prevent resin from entering the condensate demineralizer system vent and to reduce the probability of air intrusion into the reactor vessel. This item remains open pending a review of the licensee's schedule and tracking system to followup on the remaining LER's.
- E. (Open) Unresolved Item (83-19-06). NSRAC requirements for quorum and safety evaluation review. T.S. 6.5.B requires a quorum to consist of the Chairman and a majority of the members. NSRAC memo 83-21 dated July 12, 1983 states the licensee's position that since the membership consists of nine (9) members, the five (5) required for a quorum can include the Chairman. On October 12, 1983, the inspector discussed this position with the NRC:NRR Licensing Project Manager (LPM) who indicated that it was acceptable. A second question was whether NSRAC could review the ORC minutes (which include summaries of safety evaluation for design changes and procedure changes) to satisfy the T.S. requirement to review safety evaluations. The NRC LPM indicated that it was not acceptable to review the ORC minutes, and that the NSRAC was required to review the actual safety evaluations - but that this effort may be assisted by a subcommittee of NSRAC.

These positions were conveyed to the NSRAC chairman. The licensee stated (NSPAC meeting 83-08 minutes) that 1) a NSRAC subcommittee would review the plant design change safety evaluation backlog by February 1, 1984, and 2) a second subcommittee would review certain sets of procedures (not just the safety evaluations) by February 1, 1984. The inspector questioned the licensee concerning the scope of this procedure review and whether all safety related procedures and those described in the FSAR (for which a safety evaluation would be required) would be reviewed. Pending a review of the scope of this review, this item remains unresolved.

- F. (Open) Unresolved item (83-23-02). Acceptability of licensee's method of calculating secondary containment and Standby Gas Treatment System (SGTS) performance (Procedure 8.7.3), and effects of wind speed on differential pressure readings. The licensee's Nuclear Engineering Department (NED) has initiated a programmatic review of the design bases, Technical Specifications, and method of conducting the test. As an immediate step, NED issued a memo to the Station Manager on December 16, 1983 which concluded that recent tests performed on December 13, 1983 met the Technical Specification requirements (1/4 inch of vacuum with a flow rate  $\leq$  4000 cfm). This was issued to support fuel movement out of the core on December 18, 1983.

On December 20, 1983, the inspector met with the NED Fluid Systems Group Leader and Station Chief Technical Engineer to discuss the evaluation of test method. The licensee provided the inspector with a draft NED evaluation which concluded that the current station practice of subtracting base-line readings was acceptable and that the wind speed has very little effect on the average building differential pressure. This item remains unresolved pending completion of the NED evaluation and review by the NRC.



### 3. Operational Safety Verification/Emergency Safeguards System Review

#### A. Scope and Acceptance Criteria

The inspector observed control room operations, reviewed selected logs and records, and held discussions with control room operators. The inspector reviewed the operability of ECCS systems including the Emergency Diesel Generators and Standby Gas Treatment System. Tours of the reactor building, turbine building, station yard, switchgear rooms, SAS, diesel generator rooms, cable spreading room, auxiliary bay, intake structure, radwaste building, and control room (daily) were conducted. Observations included a review of equipment conditions, control room annunciators, potential fire hazards, physical security, housekeeping, radiological controls, and equipment control (tagging); in addition, records of radioactive liquid and gaseous releases from the station and sampling of the Standby Liquid Control System boron concentration were reviewed.

These reviews were performed in order to verify conformance with the facility Technical Specifications and the licensee's procedures.

#### B. Findings

- (1) On November 15, 1983 the inspector reviewed a memorandum in the control room dated November 1, 1983 entitled "Water Management Program R.O. #6". This memo included instructions (to transfer water between locations in the plant) that conflicted with approved system operating procedures. Following discussions with the inspector the licensee removed these memos from the control room to ensure that no unapproved evolutions would take place. The inspector had no further questions at this time.
- (2) On November 29, 1983, the inspector held discussions with the licensee operations staff concerning two reactor vessel level recorders that were not inking and one level recorder (LR 5049) that had the chart paper installed backwards because of lack of replacement paper. The licensee took actions to improve these conditions. Proper operation of recording equipment will continue to be reviewed by the inspector during routine tours of the station.
- (3) On November 29, 1983, the inspector held discussions with the Watch Engineer concerning degrading tagging and locking practices in two areas. First, plastic tie wraps used to provide a "locking" device (on hot Reactor Core Isolation Cooling system steam valves) were being damaged by the high temperatures, and secondly, temporary make-up demineralizers were removed for regeneration without adequate red tagging of the boundary valves. These areas were immediately corrected by the licensee and steps initiated to improve the type of locking devices used on hot components. No violations were identified.

- (4) On December 10, 1983, the licensee placed the plant in cold shutdown to begin a refueling and modification outage. The inspector observed control room activities and reviewed logs and records in order to verify that the plant shutdown and cooldown were in accordance with the NRC's August 26, 1983 IGSCC Inspection Order Confirming Shutdown, the Technical Specifications (T.S.), and the licensee's procedures.

The licensee's records indicated that the initial shutdown was properly controlled and resulted in reaching the cold shutdown mode at about 10:25 am on December 10, 1983. Logs indicated that the cooldown of the reactor coolant system was performed in accordance with T.S. limits ( $4100^{\circ}$  F/hour). At 11:00 am on December 11, 1983, the licensee initiated a cooldown of the reactor vessel head via the head spray mode of the Residual Heat Removal system. The inspector noted that this evolution was authorized, that the limit of  $1000^{\circ}$  F/hour was not exceeded ( $390^{\circ}$  F to  $150^{\circ}$  F in 5 hours) on the reactor vessel shell or flange, and that the reactor vessel metal temperatures were recorded. However, T.S. 4.6.A.1 requires logging every 15 minutes, the vessel shell, flange, and both recirculation loop temperatures during cooldowns. This was not done and constitutes a violation of the Technical Specifications (83-24-01). (Although these parameters are recorded, this does not assure that operators are monitoring these parameters every 15 minutes).

The inspector stated that although the reactor coolant system water temperature was relatively stable at about  $100^{\circ}$  F, the spraying of 900 gpm of this water onto a  $390^{\circ}$  F reactor vessel head constituted a cooldown and the logging of temperatures as described by T.S. 4.6.A.1 was required. The licensee acknowledged the inspector's comments.

- (5) The inspector noted that the control room ambiance has been greatly improved because of the licensee's use of shift administrative assistants in the "control room annex". This has resulted in a much quieter and less cluttered control room than has been observed in past outages. The majority of administrative document processing and filing is performed outside the physical confines of the control room. During tours of the control room, operators were knowledgeable of plant conditions and annunciators. No violations were identified.
- (6) On December 22, 1983, the inspector held discussions with the licensee's radiation protection management personnel concerning policies regarding keeping exposures as low as reasonable achievable (ALARA). Specifically, the inspector stated that several contractor employees stated that they had to wait in the reactor building while not actively engaged in work. The dose rates in the areas these personnel were waiting in ranged from .5 to 6 mrem/hr. Also

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The licensee's Chief Mechanical Engineer stated that a policy statement would be issued to all licensee and contractor management personnel regarding personnel loitering in the process buildings and receiving unnecessary exposure.

Also, on December 30, 1983, two workers questioned the inspector whether work conducted two days earlier in the condenser bay could have been done in lower dose areas outside the bay. The workers stated that two days earlier, they had received 10 mrem of whole body radiation dose during two hours work in the bay.

Discussions with licensee's management indicated that measures had already been taken to help assure that work was done outside the condenser bay in low dose areas when possible. Recent radiation surveys indicated that general area dose rates in the condenser bay were low, 2-4 mrem/hr and that health physics personnel were implementing the management policy of performing work in low dose areas.

This licensee action appears adequate to help insure that worker's radiation doses are maintained ALARA in the Condenser Bay.

#### 4. Followup on Events, Trips, and Licensee Event Reports (LERs)

- A. LERs submitted to the NRC:Region I office were reviewed to verify that the details were clearly reported and that corrective actions were adequate. The inspector also determined whether generic implications were involved and if on site followup was warranted. The following reports were reviewed.

<u>No.</u>	<u>Subject</u>
83-56	Sliding fire door inoperable
83-57	Missed surveillances
83-58	Main stack sample pump out of service
83-59	Torus temperature recorder inoperable
83-60	CRD No. 10-11 accumulator inoperable
83-61	Drywell-Torus vacuum breaker alarm inoperable
83-62	Secondary containment dampers inoperable
83-63	Recirculation system piping cracks
83-64	Dryer-separator plugs not removed during refueling operations



## B. Findings

- (1) LER 83-57; On November 18, 1983, the licensee reported the results of an initial evaluation of a Technical Specification assessment being performed to determine the degree of implementation of the T.S. surveillance requirements with station procedures. They identified three areas that were in violation of the T.S.: (1) response time testing of eight RPS relays (2) ATWS/ARI functional testing prior to each reactor startup, and (3) the setpoint for containment spray permissive. The licensee declared the RPS system inoperable because of item (1) above and commenced a plant shutdown at 5:40 p.m. on November 18, 1983. The station procedure for RPS response time testing did test all RPS functions (i.e., High Pressure, Low Level MSIV Closure, etc.), but failed to check independently the timing of both individual contacts in the MSIV and Turbine Stop Valve circuitry where there are two contacts in parallel. At 7:17 p.m. on November 18, 1983, the shutdown was secured upon successful completion of testing.

The inspector verified that the licensee revised the station procedures for RPS response time (during ORC meeting No. 83-97; procedures 3.M.3-11.1 through 3.M.3-11.4) and containment spray pressure permissive setpoint (during ORC meeting No. 83-96; procedure No. 8.M.2-2.1.5). The licensee stated in the LER that a change to the startup procedure was initiated to include the ATWS functional tests. This change has not been made yet. However, the licensee has shutdown for a refueling/maintenance outage and does not need this procedure change prior to startup in late 1984.

The inspector met with the licensee to discuss the results of the licensee's report dated August 31, 1983, "T.S. Assessment". There are additional questions in this report concerning adequacy of station procedures for which the licensee's review has not been completed. The licensee stated that a plan and schedule for completion of this activity would be available by the end of January, 1984.

For additional comments concerning the licensee's surveillance program see Paragraph 5 below.

No violations (other than those licensee identified violations) were identified in the review of this LER.

- (2) LER 83-64; At 4:00 p.m. on December 20, 1983 the licensee suspended movement of irradiated fuel from the reactor vessel (RV) to the spent fuel pool because of the identification (by the on-coming Watch Engineer) that there may have been a violation of T.S. 3.5.F.5. This specification states that when irradiated fuel is in the RV and the torus is drained, that one control rod drive mechanism (CRD) may be removed provided that (1) no additional work was in progress that



had the potential to drain the RV, (2) the core spray pumps were operable and alligned to the condensate storage tanks (CST), and (3) that the RV cavity, the spent fuel pool (SFP), and the dryer-separator pool (DSP) were flooded up.

The inspector reviewed this event, the requirements of the T.S. and the Bases of the T.S. The intent of the specification is to have a large enough source of water (from gravity drain) to keep the core covered if a leak developed while changing CRD's with the torus drained. In this case, there was no work in progress that had the potential for draining the vessel, and no CRD changeout in progress. In addition, the core spray pumps were operable and lined up to the CST and the RV, SFP, and DSP were flooded up. However, the shield plugs were still installed between the RV cavity and DSP, and therefore, the water source in the DSP would not be available.

The inspector verified that refueling was suspended until the shield plugs were removed. The licensee stated that a revision to procedure 4.3 "Fuel Handling" would be made and that the T.S. would be reviewed for possible revision for clarity.

The inspector had no further questions. No violations (other than the licensee identified violation) were identified in the review of this LER.

## 5. Surveillance Activities

- A. The inspector reviewed the licensee's actions associated with surveillance testing in order to verify that the testing was performed in accordance with approved station procedures and the facility Technical Specifications.

The following tests were reviewed/observed:

- Routine testing of the High Pressure Coolant Injection suction crossover logic to the Condensate Storage Tank on November 10, 1983.
- Routine surveillance of reactor coolant system parameters (Oper 7) during cooldown on December 10, 1983.

The inspector also performed a review of the surveillance program with respect to Technical Specification requirements. This review also included followup of the licensee's own efforts in this area, performed in part, due to the requests of the Institute of Nuclear Plant Operations (INPO). As described in Paragraph 4 above (LER 83-57), the licensee performed a comparison of the T.S. vs surveillance procedures, identified several problem areas and has initiated actions to correct them.

## B. Findings

- (1) The licensee's report "Summary Report - T.S. Assessment" dated August 31, 1983, was extensive. Each T.S. surveillance requirement was matched with a station procedure in a matrix. About 54 potential discrepancies and questions were developed and 20 of these were recommended for priority review. Out of these 20, the licensee reported three violations in LER 83-57. The licensee is continuing the evaluation and resolution of the other items.

The inspector initiated an independent review to determine the thoroughness of the licensee's report. This review continued beyond the end of this reporting period. The inspector questioned T.S. 4.9.A.1.e and the licensee's implementing procedure 7.1.36 which address monthly sampling of Diesel Generator fuel oil. The licensee uses data from the ASTM standards referenced in the T.S. (to compare with the results received from a vendor) but the inspector questioned the licensee as to whether the actual acceptance criteria specified should be included in the surveillance procedure since the licensee was unable to provide the inspector with a copy of the standard.

The inspector will continue to review the licensee program in a future inspection (IFI 83-24-02).

- (2) The inspector noted that 1) the licensee has submitted several LER's and 2) the NRC has issued several violations for failure to implement T.S. required surveillances over the past three years. In 1981, the licensee used the resources of a consultant and computerized the Master Surveillance Tracking Program. NRC Report No. 82-30 documented the improvements that the licensee had made in this area and described the procedural controls for scheduling and tracking surveillances, including issuing variance reports to the Station Manager.

The licensee has two methods of ensuring that T.S. changes are incorporated into plant surveillance procedures: 1) station procedure 1.2.1, Operations Review Committee, requires the ORC to convene upon receipt of a license amendment to ensure that the changes are implemented; and 2) the licensee's startup-modification management group tracks license changes to ensure that the appropriate procedures have been changed prior to plant startup from a refueling outage. The ORC chairman stated that, for a recent Amendment No. 71, the procedure changes were implemented prior to receipt of the Amendment. Also, the licensee plans to make the matrix of T.S. vs licensee procedure a controlled document and has had separate discussions with INPO on this subject.

(3) The inspector reviewed the licensee's internal Q.A. activities in this area. The inspector noted the following:

- Surveillance activities are audited at least annually but not as a separate subject. The inspector reviewed annual operations audits between 1977 - 1983 and verified that reviews of T.S. surveillance requirements were being performed. Audit No. 81-5 reviewed changes resulting from Amendment 42 to the license.
- The inspector also reviewed selected audit check lists and verified that the auditors were reviewing the technical adequacy (acceptance criteria) of the surveillance procedures reviewed.
- The Q.A. Department does not verify that all license amendments are implemented properly.
- The Q.A. Department did not have a program for observing on-going operations and surveillance activities. However, the licensee has just recently established a new program under the direction of the Q.A. Audit Group Leader for direct observation or "surveillance" monitoring. Schedules were being prepared for implementation to begin on January 1, 1984, and
- The Q.A. Audit Group is preparing a matrix of T.S. surveillances and implementing procedures vs. Q.A. Audits performed in the recent past in order to schedule future audits for those areas not looked at.

The inspector determined that the licensee's current plans were adequate to provide assurance that T.S. required surveillances were being performed.

#### 6. Maintenance/Modification Activities

- A. The inspector reviewed the licensee's actions associated with maintenance and modification activities in order to verify that they were conducted in accordance with station procedures and the facility Technical Specifications. The inspector verified for selected items, that the activity was properly authorized and that the appropriate radiological controls, equipment control tagging, and fire protection were being implemented.



The items/documents reviewed included the following:

- Maintenance Request (M.R.) 83-344; Repair reactor water conductivity recorder
- M.R. 83-349; Replace leaking valve No. 111 on control rod drive unit No. 10-11 accumulator
- M.R. 83-362; Ventilation damper gears out of alignment
- M.R. 83-27-60; Repair salt service water chlorine feed pumps

The inspector also held discussions with the licensee concerning conditions noted during plant tours.

#### B. Findings

- (1) On November 13, 1983, the inspector reviewed the results of a Nuclear Engineering Department memorandum (NED 83-763) which documents an evaluation of visible cracking on recently made grout pads for the Scram Discharge Volume tank modifications (the inspector had previously questioned the licensee on this item). The grout condition was acceptable and the inspector had no further questions.
- (2) On November 29, 1983, the inspector held discussions with the licensee concerning the inoperable ground detection unit on the 'A' 125v dc battery bus. The licensee was taking periodic ground measurements until long term repairs can be made. The licensee stated that it was difficult to obtain replacement parts and was considering a modified design. The inspector determined that the ground detection system was not required for operability of the safety-related 125v dc bus but provided advance warning of degradation. The condition of the ground detection system will be reviewed during future routine inspection of the facility.

No violations were identified during this review.

#### 7. Refueling Activities - Outage Preparations

The inspector reviewed the completion of new fuel receipt inspection, preparations for the outage, and unloading of the reactor vessel components including irradiated fuel.

The licensee inspected new fuel in accordance with procedure No. 4.2, Inspection and Channeling of Nuclear Fuel, Revision 19. An additional section was added to the licensee's procedure (at the request of a General Electric Co. representative) to inspect the corner fuel rods for evidence of fretting (surface denting caused by the spacers during transportation). One pin was rejectable and a Nonconformance Report (83-124) was written on assembly FBLY 7614 rod H-8. On December 9, 1983 a vendor representative assisted the licensee in changing out the one defective pin.

On December 22, 1983, the inspector observed movement of four irradiated fuel bundles out of the core and into the spent fuel pool. The licensee was observed to be following the precautions and requirements of procedure No. 4.3, Fuel Handling, Revision 29. The activity was supervised by a SRO licensed person, and proper operation of the refueling bridge and mast were verified. A review of control room logs indicated that the periodic testing of refueling equipment (OPER 14, OPER 13) had been performed. In addition, the inspector verified the operability of the Emergency Diesel Generators, the Standby Gas Treatment System, and the refueling floor ventilation radiation monitors.

On December 28, and 29, 1983, the inspector observed the licensee decoupling control rods and the storage of new blades.

No violations were identified in this review.

#### 8. Performance Improvement Program (PIP) Implementation

On December 8, 1983, the inspector met with a licensee representative to review the status of a PIP Rev. 2 milestone planned for completion in November, 1983. This item is described below.

- 1.3.F (PIP 6); Complete implementation of PM Program for Master Equipment List. The licensee has established a PM administrative (tracking and scheduling) program in procedure 1.8.2. Procedure No. 3.M.1-1 is the Maintenance Department's application of the program. The inspector reviewed the licensee's planning documents for Motor Operated Valves.

The licensee also described the status of the Procedure Update Program and indicated that additional resources were being procured to meet the October, 1984 milestone date.

The licensee provided the inspector with a draft Nuclear Operations Procedure regarding training plant personnel on procedure changes. The inspector questioned the licensee concerning their previous statements that this procedure would reflect the INPO good practices since the draft did not reference these practices. The licensee stated that this would be reviewed.

No violations were identified. The inspector determined that the November, 1983 milestone was met.

#### 9. Cold Weather Preparations

The inspector reviewed equipment locations and inspected several areas of the station that were susceptible to freezing to verify the protection of equipment.

On November 17, 1983, the jockey fire pump sensing line (in the Intake Structure) was found to be heat traced with a thermostatically controlled heat tape and the electrical cord was red-tagged. However, the cord had been unplugged so that the electrical outlet could be used for a portable heater. The Watch Engineer (W.E.) immediately re-issued a new-tag and logged it into the W.E.'s Red Tag Log in the control room and plugged the heat tracing into the power supply.

A tour of the Main Stack building was also made. Conditions were similar to those described in NRC Report No. 82-30 (the heat trace was a temporary run cable and the breaker No. 13 was not labeled). Although these conditions were acceptable, the inspector questioned the licensee concerning a programmatic review of this area each year. The licensee stated that a once-per-year inspection would be performed via a procedure which would be scheduled and tracked by the computerized surveillance tracking program. The inspector had no further questions. No violations were identified.

#### 10. Unresolved Items

Areas for which more information is required to determine acceptability are considered unresolved. Unresolved items are discussed in Paragraph 2.

#### 11. Management Meetings

During the period of the inspection, licensee management was periodically notified of the preliminary findings by the resident inspectors. A summary was also provided at the conclusion of the inspection and prior to report issuance.