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U. S. NUCLEAR REGULATORY COMMISSION

Region I

Docket/Report: 50-317/84-23 License: DPR-53
50-318/84-23 DPR-69

Licensee: Baltimore Gas and Electric Company

Facility : Calvert Cliffs Nuclear Power Plant, Units 1 & 2

Inspection At: Lusby, Maryland

Dates: August 21 - September 25, 1984

Inspectors: K Fevlic 11/8/84
FOR T. Foley, Senior Resident Inspector date

D C Trimble Nov 8, 1984
D. C. Trimble, Resident Inspector date

Approved: Ele McCabe, for 11/9/84
T. C. Elsasser, Chief, Reactor Projects Section 3C date

Summary:
August 21 - September 25, 1984: Inspection Report 50-317/84-23, 50-318/84-23.

Areas Inspected: Routine resident inspection (194 hours) of the control room, accessible parts of plant structures, plant operations, radiation protection, physical security, fire protection, plant operating records, maintenance, surveillance, radioactive effluent sampling program, open items, TMI Action Plan items, and reports to the NRC.

Results: A violation was identified for not following facility instructions when installing a blank flange in the Unit 1 chemical and volume control system (Detail 4d). A second violation was identified for a degraded barricade and posting for a high radiation area (Detail 4c). The inspection also found no apparent consideration of the potential for an unreviewed safety question when temporary changes are made to systems described in the FSAR. Review of this matter is continuing (Detail 4d).

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DETAILS

1. Persons Contacted

   Within this report period, interviews and discussions were conducted with various licensee personnel, including reactor operators, maintenance and surveillance technicians and the licensee's management staff.

2. Summary of Facility Activities

   Throughout the period both units were normally operating at 100% power with the exception of routine power reductions of approximately 25% to clean condenser water box tubes.

   On August 23, 1984 during troubleshooting of control rod position indication oscillations on Unit 1, Control Element Assembly CEA-2 dropped to the full in position. The licensee reduced power to 70% as required and followed the applicable Technical Specification action statement. Control modules were replaced in the coil programmer and the CEA was returned to service.

   On August 29, 1984, Unit 1 experienced an abundance of fish accumulating on the circulating water traveling screens causing an excessive differential pressure across the screens and eventually resulting in the operators manually tripping the reactor. This is further addressed herein under "Events Requiring Prompt Notification". On August 30, Unit 1 was returned to power operations.

   On September 11, 1984, the licensee completed the Annual Emergency Response Exercise and successfully demonstrated that the health and safety of the public could adequately be protected. This is detailed in Inspection Report 84-24.

   On September 17, 1984, a Unit 2 Control Element Drive Mechanism lift coil shorted out and dropped CEA-3. The licensee commenced a normal shutdown and cool down to facilitate repairs. This is discussed in detail under "Prompt Notifications". The licensee returned Unit 2 to service on September 21, after completion of CEA testing.

   Both units continued full power operations throughout the rest of the period.

3. Licensee Action on Previous Inspection Findings

   (Closed) Inspector Follow Item (317/83-02-02) Licensee to investigate cause of a January 18, 1983 event in which boron stratified in the Unit 1 Refueling Water Tank (RWT). The licensee determined that boric acid had recently been added to the tank and the samples were taken before the tank contents were adequately mixed. The licensee, by procedure, now recirculates the RWT with a Spent Fuel Pool Cooling Pump (which has a larger capacity than the installed RWT recirculation pump) after chemical additions to speed up tank mixing. Thereafter stratification is prevented by use of the installed RWT recirculation pump. This item is closed.

4. Review of Plant Operations

a. Daily Inspection

During daily control room observation the following were checked: control room manning, access control, adherence to procedures and LCO's, instrumentation, recorder traces, reactor protection systems, control rod positions, containment temperature, pressure and humidity, control room annunciators, radiation monitors, emergency power source operability, control room logs, shift supervisor logs, tagout logs, operating orders, and a random sampling of emergency system valve line-ups on the control panels.

Additionally, during routine tours of the facility the inspectors ascertained that activities observed were consistent with plant technical specifications, the security manual and plant procedures. The following were specifically observed during plant tours: Security access to the protected and vital areas, radiological controls, transportation and handling of radioactive waste, fire protection and housekeeping controls, equipment condition, quality control involvement and degree of direct management involvement in site activities.

-- On August 24, 1984, while at 100% power the licensee identified and noted in the Shift Supervisor's Log that both Power Operated Relief Valves (PORVs) for Unit 2 were found in the "override" position. This would prevent the PORVs from automatically opening if required. Operators immediately placed the switches in the "Auto" position. Technical Specification 3.4.3(a) requires: with one or more PORVs inoperable, within one hour either restore the PORVs to operable status or close the associated block valves and remove power from the block valves; otherwise be in at least hot standby within the next six hours and in cold shutdown within the following 30 hours. Calvert Cliffs Operating Procedure OP-1 "Plant Startup from Cold Shut Down to Hot Standby", Attachment 1, Step 15 requires operators to place the PORVs in the "normal" position. The PORV switch is a two position "Auto/Override" switch. A related switch, called the MPT (Minimum Pressurization Temperature) enable switch has two positions "Enable/Normal". Step 15 in the procedure was signed as being completed. Discussions with the licensee indicate no other work or conditions existed or occurred which could have repositioned the PORV switch, and the step was apparently signed then inadvertently not completed or interpreted to mean return the MPT switch to normal. This failure to follow procedures constitutes a "licensee identified violation" pursuant to the NRC enforcement policy in that (1) the licensee identified the item, (2) reported it to the NRC resident inspectors, (3) the violation was not a significant one, (4) the event was immediately and adequately corrected and (5) the event could not have been expected to have been prevented by corrective action from a previous violation.

The licensee revised procedure OP-1 (Revision 23) to more clearly detail a specific step which specifies the switch numbers HS-1406 and 1408 and differentiates the PORV switches from the MPT enable switches. The event was not significant in nature because the purpose of the PORVs is to reduce the number of challenges to the pressurizer code safety valves. The bases for the TS requirement 3.4.3 is to ensure isolation capability for the reactor coolant system should a PORV become inoperable in the open position. Since the "override" position prevents automatic opening and maintains the PORV shut, this event does not violate the TS bases, though it does negate the purpose of the PORVs.

In accordance with the NRC enforcement policy a citation will not be issued. The inspectors will continue to routinely monitor licensee activities regarding adherence to procedures. This event appears to be an isolated case since, in the past, operator adherence to procedures has generally reflected strict verbatim compliance.

b. System Alignment Inspection

Operating confirmation was made of selected piping system trains. Accessible valve positions and status were examined. Power supply and breaker alignment was checked. Visual inspections of major components were performed. Operability of instruments essential to system performance was assessed. The following systems were checked:

-- Auxiliary Feedwater System checked on September 11, 1984. For this system, the following items were also reviewed: the licensee's system lineup procedure(s); equipment conditions/items that might degrade system performance (hangers, supports, housekeeping, etc.); and valve position/locking (where required) and position indication, and valve operator power supply availability.

-- Waste Gas System checked on September 7, 1984.

During an inspection of the Waste Gas System on September 7, 1984, the inspector noted that the pressure transmitter for the #11 Waste Gas Decay Tank (WGDT) (0-PT-2188) was not included on a periodic calibration check program. Its calibration had apparently not been checked since 1974. The inspector reported this to the General Supervisor, Electrical and Controls (GS,E&C) who stated he would look into the problem. On September 21, 1984 the licensee initiated a change to their planned maintenance program to include the WGDT pressure transmitters. The inspector also noted that the relief valve for #11 WGDT has not been tested since plant construction. The valve is on a list of relief valves scheduled to be tested by the end of the first 10 year inservice testing period. Thereafter they intend to test these relief valves every five years.

In a subsequent discussion, the Electrical and Controls group Engineering Unit Supervisor stated that over the next year he will be reassessing their overall program for periodic instrument calibration checks. Initially their plans are to develop a multi-level program in which the more critical instruments are identified and given highest priority and/or check frequency. Lesser important instruments would be classified at a lower level and be assigned the appropriate priority. Such an overall program and instrument review should help correct omissions of instruments like the WGDT pressure transmitters. Licensee actions to develop the above calibration program will be followed by the NRC (317/84-23-04).

c. Biweekly and Other Inspections

During plant tours, the inspector observed shift turnovers; boric acid tank samples and tank levels for compliance with Technical Specifications; and the use of radiation work permits and Health Physics procedures. Area radiation and air monitor use and operational status was reviewed. Plant housekeeping and cleanliness were evaluated. A random verification of tagouts was conducted. Findings were acceptable except as follows.

-- On September 18 with Unit 2 at Cold Shutdown, the inspector conducted a tour of Unit 2 to witness maintenance activities on the control rod position indicator. During the tour, the inspector noted that the 69 foot access to the No. 21 Reactor Coolant Pump bay was not barricaded nor adequately posted as a High Radiation Area. Licensee surveys of the bay revealed several areas greater than 100 mrem/hr. An appropriate barrier and posting had been installed but were subsequently taken down and left in the immediate area by an individual entering the bay. Only personnel with health physics training (or personnel escorted by trained individuals) were allowed access to the Containment Building. The barrier and posting were still visible to individuals entering the bay and would have provided warning to those people. However, Technical Specification 6.12.1 requires areas greater than 100 mrem/hr to be barricaded and conspicuously posted as a High Radiation Area. This is a violation (318/84-23-01) because the taking down of the barrier and sign removed the required barricade and conspicuous posting.

A related concern noted by the inspector was that other barricades and postings used during power operations were not being properly reposted after entrance to the area. For example, postings of the entrance to the Containment 10 ft. level located on the 45 ft. level were left undone and set aside. The Health Physics Supervisor was notified of these findings and areas were then reposted. The inspector and Health Physics It appeared that these problems were caused by a lack of concern on the part of personnel frequenting the controlled areas. This was discussed with the Operations Supervisor who provided reminders to operations staff regarding postings requirements. As a result of the inspection, the licensee has established swinging gates with radiological control signs attached at many access ways throughout the radiologically controlled area and plans additional modifications of this nature to control access to other radiation areas.

d. Other Checks

On August 29, 1984, the licensee initiated repairs to a leaking relief valve on Unit 1 Chemical and Volume Control System (CVCS). The valve, 1-CVC-345, is located on a branch line attached to the non-safety related section of CVCS piping downstream of the flow control valves and ahead of the non-regenerative letdown heat exchanger. The piping upstream of the flow control valves is rated for full reactor coolant system (RCS) operating pressure (2250 psig). The piping on which this relief valve was installed is rated for 600 psig at 450 degrees Fahrenheit (2 inches diameter seamless stainless steel ASTM A 376 or ASTM 312 Type 304). The plant drawing (OM-73, sheet 3 of 3, Revision 6 dated August 15, 1984) showed incorrectly that a flange existed connecting the upstream side of the relief valve branch line to the CVCS piping. The drawing also showed that the relief valve branch line connected to a removable section of CVCS piping flanged at both ends (similar to a spool piece) located between the flow control valve and non-regenerative letdown heat exchanger. The maintenance supervisor and shift supervisor reviewed the drawing and decided to remove the relief valve from the branch line, install blank flanges on the upstream and downstream side of the relief valve, and return the CVCS system to operation while the relief valve was being fixed. However, since the drawing was incorrect, no flange existed between the relief valve and the CVCS piping. Due to either the drawing error or a misunderstanding on the part of the maintenance personnel of the intentions of the shift supervisor, the maintenance personnel removed the spool piece section of CVCS piping, blank flanged the main flow CVCS piping, and reported that the blank flanges had been installed. The maintenance procedure in use did not include any detailed instructions for the removal of the relief valve from the system. Operations personnel cleared the associated tagout, which was posted on remotely operated valve handwheels, without verifying that the system was intact. The letdown control valves were opened pressurizing the main flow CVCS piping. The 600 psig design piping downstream of the flow control valve between the valve and blank flange was pressurized to 2250 psig. No pipe leakage resulted. A visual examination was conducted of the overpressurized piping, and the 28 piping welds were independently checked. No damage was identified. On August 30, 1984, an engineering analysis was performed which showed that resultant stresses were within the limits allowed by ASME Section III.

If the overpressurized piping had ruptured, redundant isolation valves between the affected piping and the RCS would have automatically closed due to low RCS pressure and/or high non-regenerative heat exchanger room pressure protection signals. Therefore, the potential effect on nuclear safety was minimal.

Calvert Cliffs Instruction CCI 117D, Temporary Mechanical Device, Electrical Jumper and Lifted Wire Control, dated May 24, 1984 requires administrative controls for the installation and removal of blank/blind flanges that are not a design part of a system. In the case of mechanical devices, the devices are required to be logged and tagged. For non-safety-related items, review and approval prior to installation is required by the respective technical supervisor and two senior licensed individuals. Removal of the temporary devices is authorized by the shift supervisor. This procedure was not followed by the licensee in this instance. Use of the CCI 117 controls may have prevented the piping overpressurization by more clearly specifying to both operations and maintenance personnel where the blank flanges were to be installed.

The requirements of 10CFR50.59, regarding the need for licensees to review proposed design changes to verify unreviewed safety questions are not involved, also apply to temporary modifications (e.g., changes resulting from the use of temporary mechanical devices, electrical jumpers and lifted wires). When the licensee decided to remove the CVCS relief valve (which is shown in an FSAR drawing) and then return the system to operation with a blank flange installed, the evolution was no longer simply a maintenance activity. Instead it was now a temporary plant modification, and the requirements of 10CFR50.59 applied. CCI 117D constitutes the only identified licensee control for these types of temporary modifications. CCI 117D does not require personnel approving temporary modifications to first examine the changes for unreviewed safety questions. It does require a review by plant operators and the Plant Operations and Safety Review Committee of safety-related items only. It was not established that changes to non-safety-related systems which are within the scope of 10 CFR 50.59 receive a review for unreviewed safety questions. This was discussed with licensee management personnel and is the subject of an in-progress NRC review. The item is unresolved pending the outcome of this review (317/84-23-01).

The licensee's failure to follow the requirements of CCI 117D is a violation (317/84-23-02).

5. Events Requiring Prompt Notification

The circumstances surrounding the following events requiring prompt NRC notification pursuant to 10 CFR 50.72 were reviewed. For those events resulting in a plant trip, the inspectors reviewed plant parameters, chart recordings, logs, computer printouts and discussed the event with cognizant licensee personnel to ascertain that the cause of the event had been thoroughly investigated, identified, reviewed, corrected, and reported as required.

-- At 9:58 p.m. on August 28, 1984 with Unit 1 operating at 100% power, reactor operators manually tripped the reactor following a large accumulation of fish on the intake structure (circulating water) traveling screens numbers 11A and B and 12A and B. To prevent damage to these screens from high differential pressure, the two associated circulating water pumps had to be tripped. The operators realized that condenser vacuum could not be maintained without adequate circulating water flow and elected to trip the plant. Oxygen concentration in the Chesapeake

Bay was less than 3 ppm. The licensee has experienced similar influxes of fish when oxygen levels are low. General Supervisor Operations (GSO) Standing Order 84-3 required stationing of an operator at the intake structure (to run all the screens continuously) whenever bay temperature exceeds 75 degrees Fahrenheit, wind is from the west or southwest at speeds exceeding 5 mph for 24 hours, and the oxygen concentration is down to 3 ppm. In this case, the wind criteria was not met and an operator was not required to be stationed at the screens. On September 13, 1984 the GSO order was modified to station the operator whenever the oxygen concentration decreases to 3 ppm by 9:00 p.m. (oxygen concentration falls during the night). On August 30, at 4:00 p.m. the unit returned to power operations. This event was reported to the State of Maryland as well as the NRC.

-- At 12:18 on September 14, 1984 with Unit 1 at 100% power Control Element Assembly (CEA) #3 in group 4 dropped to the fully inserted position. The licensee was unable to withdraw the rod. Technical Specifications (TS) permitted continued operation, provided the group was aligned with the inoperable rod. This alignment would have resulted in a power level of 20% power. The licensee, however, elected to shut down and repair the inoperable rod. The cause of the dropped rod was determined to be an electrical short in the Control Element Drive Mechanism (CEDM) coil stack (upper gripper coil). The unit was placed in Mode 5 to facilitate repairs.

The inspector noted that for this situation, TS 3.1.3.1.f in combination with TS 4.1.1.1.1 required that shutdown margin be determined to be greater than or equal to 4.3% delta k/k by 3:15 p.m. At 1:44 p.m. the inspector reminded the Control Room Operators of the requirement to do the shutdown margin calculation. It appeared that operators were not cognizant of this requirement even though it was mentioned in the emergency procedure in use (EOP 11). The calculation was then begun at 2:00 p.m., and determined adequate margin was available. TS requirements were therefore met. The inspector expressed concern to the General Supervisor, Operations (GSO) that the operators may not have been aware of the requirement for a shutdown margin calculation.

Operations personnel (including supervisors) routinely check to ensure compliance with procedural and Technical Specification requirements. Ample time remained to detect the need for and perform the margin calculation. Problems have not previously occurred in the performance of shutdown margin checks. Therefore, no unacceptable conditions were identified in this case.

While the unit was shut down, the CEDM coil stack was replaced with a similarily designed coil stack and the unit returned to power operation on September 21, 1983, after CEDM testing was complete. The inspector observed a portion of the removal of the failed coil stack insertion of the new stack and reviewed test data. No inadequacies were identified.

6. Observations of Physical Security

Checks were made to determine whether security conditions met regulatory requirements, the physical security plan, and approved procedures. Those checks included security staffing, protected and vital area barriers, vehicle searches, and personnel identification, access control, badging, and compensatory measures when required. Backshift inspections revealed security personnel were alert and attentive to their duties in all cases.

7. Review of Licensee Event Reports (LER's)

a. LER's submitted to NRC:RI were reviewed to verify that the details were clearly reported, including accuracy of the description of cause and adequacy of corrective action. The inspector determined whether further information was required from the licensee, whether generic implications were indicated, and whether the event warranted onsite followup. The following LER's were reviewed.

LER No.	Event Date	Report Date	Subject
Unit 1			
84-07	07/24/84	08/23/84	Loss of 4160 Emergency Electric Bus.
83-09	02/10/83	07/30/84	Followup Report on Missed Snubber Surveillance.
Unit 2			
84-06	07/09/84	08/06/84	Reactor Coolant Leakage Greater than TS Limit.
84-07*	08/22/84	09/20/84	PORV Override Handswitches Left in Override Position.
84-08	08/08/84	09/04/84	Battery Inoperable.
83-65	12/02/83	08/13/84	Followup Report of Failed Reed Position Transmitter.
83-75	12/10/83	08/13/84	Revision 1 - Failed Control Element Motion Inhibitor.

* Discussed in detail in this report.

b. For the LER's selected for onsite review, the inspector verified that appropriate corrective action was taken or responsibility assigned and that continued operation of the facility was conducted in accordance with Technical Specifications and did not constitute an unreviewed safety question as defined in 10 CFR 50.59. Report accuracy, compliance with current reporting requirements and applicability to other site systems and components were also reviewed. No inadequacies were found.

-- Details regarding LERs 84-06 and 84-08 are addressed in Inspection Report 50-317, 318/84-19.

8. Plant Maintenance

The inspector observed and reviewed maintenance and problem investigation activities for compliance with regulations, administrative and maintenance procedures, codes and standards, proper QA/QC involvement, safety tag use, equipment alignment, jumper use, personnel qualifications, radiological controls for worker protection, fire protection, retest requirements, and reportability per Technical Specifications. The following activities were included, and no inadequacies were found:

-- MR X-84-183, Repair of Diesel Generator #11 Service Water Control Valve 1-CV-1587 observed on September 13, 1984.

-- Troubleshooting of Channel A Reactor Protection System Axial Shape Index observed on September 13, 1984.

-- PMS 2-58-E-A-1, Annual checks on Reactor Trip Breakers observed on September 13, 1984.

-- MR 0-84-5310, Plugging of Tube on Service Water Heat Exchanger #11 observed on September 13, 1984.

9. Surveillance Testing

The inspector observed parts of tests to assess performance in accordance with approved procedures and LCO's, test results (if completed), removal and restoration of equipment, and deficiency review and resolution. The following test was reviewed with no inadequacies found:

-- STP M522 Reserve Battery Service Test observed on September 13, 1984.

10. Emergency Response Exercise

The inspectors observed the licensee's 1984 Emergency Response Plan Exercise held on September 11, 1984. The inspectors were part of a larger NRC inspection team. The inspectors also attended two licensee pre-drill briefings for evaluators and controllers and the post drill critique. Further details regarding this NRC review will be documented in Inspection Report 317/84-24, 318/84-24.

11. Licensee Action on NUREG 0660, NRC Action Plan Developed as a Result of the TMI-2 Accident

The NRC's Region I Office has inspection responsibility for selected action plan items. These items have been broken down into numbered descriptions (enclosure 1 to NUREG 0737, Clarification of TMI Action Plan Items). Licensee letters containing commitments to the NRC were used as the basis for acceptability, along with NRC clarification letters and inspector judgment. The following item was reviewed.

-- I.A.1.3.(2) Shift Manning-Minimum Crew Size. Aspects of this requirement regarding presence of a Senior Licensed Operator in the Control Room were addressed in Inspection Reports 317/81-15, 318/81-14 (Section 10) and 317/81-18, 318/81-17 (Section 12). Technical Specifications addressing minimum shift staffing were issued by NRR on March 9, 1982 (Amendments 68 for Unit 1 and 50 for Unit 2). In the associated Safety Evaluation NRR concluded that the shift staffing requirements of item I.A.1.3.(2) were met by those Technical Specifications. This item is closed.

12. IE Bulletin Followup

The inspector reviewed licensee actions on the following IE Bulletins to determine if the written responses were submitted within the required time period, if the responses included the information requested including adequate corrective action commitments, and if the licensee management had forwarded copies of the responses to responsible onsite management. The review included discussions with licensee personnel and observations and review of the items discussed below.

-- IEB 84-02 Failure of General Electric Type HFA Relays in Use in Class 1E Safety Systems. Licensee response to IEB 84-02 is dated July 20, 1984.

-- IEB 84-03 Refueling Cavity Water Seal. Safety Evaluation 83-45 is dated April 20, 1983 and 82-59 Supplement 1 dated October 12, 1983 regarding nozzle Dams.

The inspector discussed these bulletins and Safety Evaluations with cognizant personnel, and reviewed the response to IEB 84-02. The information discussed in the response to IEB 84-02 conforms with the requested information in the bulletin. Licensee cognizant personnel were aware of the bulletins concerns. The inspector confirmed that the corrective action stated in the response had been implemented and that documentation had been initiated to cause future preventive action regarding these purchasing of these relays.

The licensee has not yet responded to IEB 84-03, however, they have received, routed and reviewed IEB 84-03. The licensee does not plan to be in a condition (refueling) which would be applicable until late in 1985. The licensee's response to IEB 84-03 will be reviewed and corrective action verified when received. The resident inspectors will follow resolution of this item (Inspector Follow Item: 317/84-23-03).

13. Review of Periodic and Special Reports

Periodic and special reports submitted to the NRC pursuant to Technical Specification 6.9.1 and 6.9.2 were reviewed. The review covered: inclusion of information required by the NRC; test results and/or supporting information; consistency with design predictions and performance specifications; adequacy of planned corrective action for resolution of problems; determination of whether any information should be classified as an abnormal occurrence; and validity of reported information. The following periodic reports were reviewed:

-- July, 1984 Operation Status Reports for Calvert Cliffs No. 1 Unit and Calvert Cliffs No. 2 Unit, dated August 16, 1984.

-- August, 1984 Operations Status Reports for Calvert Cliffs No. 1 Unit and Calvert Cliffs No. 2 Unit, dated September 14, 1984.

-- Vermont Yankee Nuclear Power Corporation Report pursuant to 10 CFR 21.21 regarding Exide Batteries.

The review of the Vermont Yankee Part 21 report included a discussion with cognizant electrical engineering personnel on site and a review of battery inservice test results (STP-M-550 Battery 2 hour profile test) and Plant Operation and Safety Review Committee minutes. The licensee maintains safety related batteries on site made by Gould and by Exide vendors and has experienced problems similar in nature to those described in the report. The licensee identified, in POSRC meeting 84-101, broken seal nuts on Nos. 21 and 22 batteries. Surveillance testing revealed that the current carrying capacity of the batteries has not been affected. The surveillance test performed, STP-M-550, does not check the full current carrying capacity of the battery, however, the five year full load and current carrying capacity check is scheduled to be completed prior to January 1985. The licensee is currently awaiting new seal nuts. Monthly preventive maintenance checks observe the battery physical condition for damaged/broken seals, terminals, etc. The Electric and Controls Department and Engineering Department are also currently evaluating the broken nut seal problem. They have contacted the vendor and Vermont Yankee regarding the problem and expect to formalize the results of their evaluation after further testing. The licensee is responding promptly to this concern in an appropriate manner. No unacceptable conditions were identified.

14. Unresolved Items

Unresolved items require more information to determine their acceptability and are discussed in Detail 4.

15. Exit Interview

Meetings were periodically held with senior facility management to discuss the inspection scope and findings. A summary of findings was presented to the licensee at the end of the inspection.