UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
245 PEACHTREE CENTER AVENUE N.E., SUITE 1200
ATLANTA, GEORGIA 30303-1200

September 25, 2023

Bob Coffey
Executive Vice President, Nuclear Division
and Chief Nuclear Officer
Florida Power & Light Company
700 Universe Blvd
Mail Stop: EX/JB
Juno Beach, FL 33408

SUBJECT: TURKEY POINT UNITS 3 & 4 – BIENNIAL PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000250/2023010 AND 05000251/2023010

Dear Bob Coffey:

On August 17, 2023, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution inspection at your Turkey Point Units 3 & 4 and discussed the results of this inspection with Mr. Michael Pierce and other members of your staff. The results of this inspection are documented in the enclosed report.

The NRC inspection team reviewed the station's problem identification and resolution program and the station's implementation of the program to evaluate its effectiveness in identifying, prioritizing, evaluating, and correcting problems, and to confirm that the station was complying with NRC regulations and licensee standards for problem identification and resolution programs. Based on the samples reviewed, the team determined that your staff's performance in each of these areas adequately supported nuclear safety.

The team also evaluated the station's processes for use of industry and NRC operating experience information and the effectiveness of the station's audits and self-assessments. Based on the samples reviewed, the team determined that your staff's performance in each of these areas adequately supported nuclear safety.

Finally, the team reviewed the station's programs to establish and maintain a safety-conscious work environment, and interviewed station personnel to evaluate the effectiveness of these programs. Based on the team's observations and the results of these interviews the team found no evidence of challenges to your organization's safety-conscious work environment. Your employees appeared willing to raise nuclear safety concerns through at least one of the several means available.

Two findings of very low safety significance (Green) are documented in this report. Two of these findings involved violations of NRC requirements. We are treating these violations as non-cited violations (NCVs) consistent with Section 2.3.2 of the Enforcement Policy.

If you contest the violations or the significance or severity of the violations documented in this inspection report, you should provide a response within 30 days of the date of this inspection

report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region II; the Director, Office of Enforcement; and the NRC Resident Inspector at Turkey Point Units 3 & 4.

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

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

Sincerely,

Signed by Dumbacher, David
on 09/25/23

David E. Dumbacher, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Docket Nos. 05000250 and 05000251
License Nos. DPR-31 and DPR-41

Enclosure:
As stated

cc w/ encl: Distribution via LISTSERV

SUBJECT: TURKEY POINT UNITS 3 & 4 – BIENNIAL PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000250/2023010 AND 05000251/2023010 September 25, 2023

DISTRIBUTION:
R2EICS
RIDSNRRPMTurkeyPoint Resource
RIDSNRRDRO Resource
PUBLIC

ADAMS ACCESSION NUMBER: ML23267A002

X SUNSI Review		X Non-Sensitive ☐ Sensitive		X Publicly Available ☐ Non-Publicly Available	
OFFICE	RII/DRP	RII/DRP	RII/DRP	RII/DCO	RII/DRP
NAME	J. Hamman	R. Reyes	D. Jung	S. Egli	D. Dumbacher
DATE	9/19/2023	09/20/2023	9/19/2023	9/19/2023	09/25/2023

OFFICIAL RECORD COPY

U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report

Docket Numbers:	05000250 and 05000251
License Numbers:	DPR-31 and DPR-41
Report Numbers:	05000250/2023010 and 05000251/2023010
Enterprise Identifier:	I-2023-010-0038
Licensee:	Florida Power & Light Company
Facility:	Turkey Point Units 3 & 4
Location:	Homestead, FL 33035
Inspection Dates:	July 31, 2023, to August 18, 2023
Inspectors:	S. Egli, Senior Construction Inspector J. Hamman, Senior Project Engineer D. Jung, Project Engineer J.R. Reyes, Project Engineer
Approved By:	David E. Dumbacher, Chief Reactor Projects Branch 3 Division of Reactor Projects

Enclosure

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting a biennial problem identification and resolution inspection at Turkey Point Units 3 & 4, in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC's program for overseeing the safe operation of commercial nuclear power reactors. Refer to https://www.nrc.gov/reactors/operating/oversight.html for more information.

List of Findings and Violations

Failure to Identify and Correct Continued Corrosion of Metallic Motor Heater Supports at the Intake Cooling Water Structure			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000250,05000251/2023010-01 Open/Closed	[P.2] - Evaluation	71152B
The inspectors identified a Green finding and associated Non-cited Violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR 50) Appendix B Criterion XVI for the licensee's failure to identify and correct continued corrosion of metallic motor heater supports at the intake cooling water structure. Specifically, corrosion on several metallic motor heater supports at the intake cooling water (ICW) structure continued to worsen, despite an action request (AR) being written at time of discovery (AR 02219419). AR 02219419 action was closed to a work order. No action was taken on the work order and no re-evaluation was done until the issue was identified by the NRC.			

Failure to Identify and Correct a Condition Adverse to Quality on the Unit 3 Emergency Operating Procedures			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000250/2023010-02 Open/Closed	[P.2] - Evaluation	71152B
The inspectors identified a Green finding and associated NCV of 10CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," Specifically, the licensee failed to identify and correct a condition adverse to quality relating to the safety impact of not being able to perform a procedure step on the Unit 3 emergency operating procedures when it was identified that safety-related valve 3-759A failed its surveillance test due to not being able to close.			

Additional Tracking Items

None.

INSPECTION SCOPES

Inspections were conducted using the appropriate portions of the inspection procedures (IPs) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html. Samples were declared complete when the IP requirements most appropriate to the inspection activity were met consistent with Inspection Manual Chapter (IMC) 2515, "Light-Water Reactor Inspection Program - Operations Phase." The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel to assess licensee performance and compliance with Commission rules and regulations, license conditions, site procedures, and standards.

OTHER ACTIVITIES – BASELINE

71152B - Problem Identification and Resolution

Biennial Team Inspection (IP Section 03.04) (1 Sample)

(1) The inspectors performed a biennial assessment of the effectiveness of the licensee's Problem Identification and Resolution program, use of operating experience, self-assessments and audits, and safety-conscious work environment.

- Problem Identification and Resolution Effectiveness: The inspectors assessed the effectiveness of the licensee's problem identification and resolution program in identifying, prioritizing, evaluating, and correcting problems, including an in-depth corrective action program review of the following systems or portions thereof: ICW, auxiliary feed water (AFW), and vital alternating current and direct current electrical systems. The inspectors also conducted a five-year review of equipment aging issues. The corrective actions for the following notices of violation (NOVs), and NCVs were evaluated as part of the assessment: NOV 2020011-01, NOV 2021011-01, 2021-011-02, NCV 2021001-01; NCV 2021001-02; NCV 2022010-01; NCV 2022010-02; NCV 2022011-01; and NCV 2022011-02.

- Operating Experience: The inspectors assessed the effectiveness of the licensee's processes for use of operating experience.

- Self-Assessments and Audits: The inspectors assessed the effectiveness of the licensee's identification and correction of problems identified through audits and self-assessments.

- Safety-Conscious Work Environment: The inspectors assessed the effectiveness of the station's programs to establish and maintain a safety-conscious work environment.

INSPECTION RESULTS

Assessment	71152B

Assessment

1) Corrective Action Program Effectiveness

Problem Identification: The team determined that the licensee was generally effective in identifying problems and entering them into the corrective action program (CAP) at the appropriate threshold. This conclusion was based on a review of the requirements for initiating condition reports (CRs) as described in licensee procedure PI-AA-104-1000 Condition Reporting. Additionally, site management was actively involved in the corrective action program and focused appropriate attention on significant plant issues.

Problem Prioritization and Evaluation: Based on the review of condition reports and work orders, the inspectors concluded that problems were generally prioritized and evaluated in accordance with licensee guidance. The inspectors determined that adequate consideration was given to system or component operability and associated plant risk. The inspectors determined that plant personnel had generally conducted cause evaluations in compliance with the licensee's CAP procedures, and cause determinations were appropriate and considered the significance of the issues being evaluated. The inspectors documented two NCVs in the results section of this report. The NCVs related to evaluation of the condition of two plant SSCs. The licensee documented these conditions in CR 2464946 and 2464715.

Corrective Actions: Based on a review of corrective action documents, interviews with licensee staff, and verification of completed corrective actions, the inspectors determined that, generally, corrective actions were effective, timely, commensurate with the safety significance of the issues, and effective, in that conditions adverse to quality were corrected. The team determined that the licensee was generally effective in developing corrective actions that were appropriately focused.

Based on the samples reviewed, the team determined that the licensee's CAP complied with regulatory requirements and self-imposed standards. The licensee's implementation of the CAP adequately supported nuclear safety.

2) Operating Experience

The team determined that the station's processes for the use of industry and NRC operating experience information were effective and complied with regulatory requirements and licensee standards. The implementation of these programs adequately supported nuclear safety. The team concluded that operating experience was adequately evaluated for applicability and that appropriate actions were implemented in accordance with applicable procedures.

3) Self-Assessments and Audits

The inspectors determined that the licensee was effective at performing self-assessments and audits to identify issues at a low level, properly evaluated those issues, and resolved them commensurate with their safety significance. The self-assessments and audits were adequately self-critical and performance-related issues were being appropriately identified. The inspectors verified that action requests were created to

document areas for improvement and findings and verified that actions generally had been completed consistent with those recommendations.

4) Safety-Conscious Work Environment

Employees interviewed appeared willing to raise nuclear safety concerns through at least one of the several means available. Based on interviews with plant staff and reviews of the latest safety culture survey results, the team found no evidence of challenges to a safety conscious work environment. However, some of the plant staff did not know the method for initiating an anonymous concern. Some thought they could be entered in a kiosk, while some thought they could be anonymously entered into NAMS. All of those interviewed stated that they would not likely use an anonymous process since they felt comfortable entering an issue into the CAP with their name associated to it.

Failure to Promptly Identify and Correct Continued Corrosion of Metallic Motor Heater Supports at the Intake Cooling Water Structure

Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000250,05000251/2023010-01 Open/Closed	[P.2] - Evaluation	71152B

The inspectors identified a Green finding and associated NCV of 10 CFR 50 Appendix B Criterion XVI for the licensee's failure to promptly identify and correct continued corrosion of metallic motor heater supports at the ICW structure. Specifically, corrosion on several metallic motor heater supports at the ICW structure continued to worsen, despite an AR being written at time of discovery (AR 02219419). AR 02219419 action was closed to a work order. No action was taken on the work order and no re-evaluation was done until the issue was identified by the NRC.

Description: During a walkdown of the intake cooling water system, the inspectors noted corrosion on the motor heater support for the 3C ICW pump. The support is square tube steel that is welded to a mounting plate and then secured to the concrete intake cooling water structure. The corrosion was located where the tube steel meets the mounting plate, and a portion of the tube steel had eroded away, leaving a small amount of metal connecting the support to the plate. The support is for a motor heater junction box. The function of the motor heater is not an immediate concern as it is used to prevent long-term degradation of the motors when they are not in use. However, the ICW pump power conduit is connected to the frame by a small strap. Although the motor conduit is not supported by the frame, the inspectors expressed concern that if the supports were to rust through and fail, the frame and junction box would remain connected to the pump conduit and whip around during a wind event, placing stress on the motor conduit. Corrosion on the motor heater support frames was identified by the licensee in 2017 and the condition was documented and analyzed under AR 2212419. The AR was closed to a work order, which was not scheduled. Pictures of the supports filed with AR 2212419 show corrosion had worsened from 2017 when compared to their current condition in the field. However, no follow-up was conducted as the issue was being managed by the work control process.

Corrective Actions: The licensee placed this issue in their CAP under CR 02464715. The description for CR 02464715 stated in part that the previous evaluation (of AR 2212419) was no longer bounding. Therefore, the licensee completed an operability evaluation that

addressed wind loading (tornado and hurricane) and seismic effects and determined that the supports remained operable for all three Unit 3 ICW pump motor heaters.

Corrective Action References: AR 02464715

Performance Assessment:

Performance Deficiency: The licensee's failure to evaluate the effects of continued corrosion, specifically on the ICW pump motor heater supports, was a performance deficiency (PD).

Screening: The inspectors determined the PD was more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically, it could lead to eventual loss of structural integrity of support systems that could then pose a hazard to nearby safety-related ICW equipment.

Significance: The inspectors assessed the significance of the finding using Inspection Manual Chapter (IMC) 0609, Appendix A, "The Significant Determination Process (SDP) for Findings At-Power." Using Exhibit 2, "Mitigating Systems Screening Questions," of IMC 0609, Appendix A, it was determined that this finding was of very low safety significance (Green) because "Yes" was not answered to any of the screening questions.

Cross-Cutting Aspect: P.2 - Evaluation: The organization thoroughly evaluates issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. Corrosion is evaluated under procedure 0-ADM-504, "Corrosion Monitoring and Action Program," which requires new actions if the corrosion condition has progressed or worsened. The AR that originally identified the issue was closed to a work order that was never implemented. Corrosion continued to worsen without any provision to re-evaluate it.

Enforcement:

Violation: 10CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," requires that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected.

Contrary to the above, between June 2017 and August 2023, continued corrosion on several metallic motor heater supports at the ICW structure continued to worsen, despite an AR being written at time of discovery (AR 02219419). AR 02219419 actions were classified as non-conditions adverse to quality and closed to a work order. No action was taken on the work order and no re-evaluation was done until the issue was identified by the NRC. Therefore, continued corrosion effects, a condition adverse to quality, was not promptly identified or corrected.

Enforcement Action: This violation is being treated as an NCV, consistent with Section 2.3.2 of the Enforcement Policy.

Failure to Identify and Correct a Condition Adverse to Quality on the Unit 3 Emergency Operating Procedures			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000250/2023010-02 Open/Closed	[P.2] - Evaluation	71152B
The inspectors identified a Green finding and associated NCV of 10CFR Part 50, Appendix B, Criterion XVI, “Corrective Action”. Specifically, the licensee failed to identify and correct a condition adverse to quality relating to the safety impact of not being able to perform a procedure step on the Unit 3 emergency operating procedures when it was identified that safety-related valve 3-759A failed its surveillance test due to not being able to close.			
Description: On February 07, 2021, Unit 3 residual heat removal (RHR) heat exchanger outlet valve 3-759A (759A) failed to close during its IST. 759A is a manually operated valve located in the RHR heat exchanger room. The valve handle is located in the auxiliary building and uses reach rods in conjunction with gear boxes that extend to the heat exchanger room to operate the valve. 759A is a safety-related valve and Technical Specifications 3/4.5.2 requires the valve to remain opened to maintain an operable RHR heat exchanger in Modes 1 through 3. The licensee enters a 72-hour action statement when the valve is being tested for its closing function and exits the action once the valve is fully opened. In addition, during accident mitigation when changing the RHR pump suction source from the refueling water storage tank (RWST) to the containment sump, 3-759A and 3-759B valves have a safety-related function to close if either MOV-3-744A or MOV-3-744B fail to close as expected in order to ensure at least one train or subsystem of the emergency core cooling system (ECCS) remains available for the ECCS recirculation function. 3-759A and 3-759B are redundant to MOV-3-744A & MOV-3-744B and constitute a separate train or subsystem capable of performing the safety function if the other train or subsystem is incapable of performing the function. The closure of the MOV-3-744A, MOV-3-744B, 3-759A, and 3-759B are directed by the station’s emergency operating procedure 3-EOP-ES-1.3, Revision 7, Transfer to Cold Leg Recirculation. The step to close 3-759A and 3-759B is directed by the response not obtained (RNO) step, which would be taken if either MOV-3-744A or MOV-3-744B fails to close. In October and November of 2021 during the Unit 3 outage, the licensee made repairs to 759A, however, the post maintenance test (PMT) was not performed until March of 2022, at which time the PMT failed as the valve could not close. In May of 2022, the licensee initiated engineering design change EC-297540 to modify the reach rod turning mechanisms and the gear boxes. Some of the parts for installing the modification would not be available until first quarter of 2023 and therefore 759A would not be able to close until then. In June of 2022, the inspectors noted that the licensee had not assessed the impact to EOP-ES-1.3, Revision 7, as a result of 759A not being able to close during the EOP RNO. The licensee acknowledged the issue and initiated AR 2430592 to assess the impact of the 759A condition on EOP response. The licensee's evaluation identified an alternate flow path configuration that could be used in the event 759A could not be closed during EOP execution, which would satisfy the required conditions for containment recirculation to cold leg injection. Standing Operations Order (SOO) 22-001 was developed which included detailed step by step instructions, precautions, and a highlighted print describing the specific valves that needed to be manipulated to achieve the required ECCS flow path configuration. On July 2, 2022, SOO 22-001 was approved by the station management and was implemented, and all licensed			

operators were trained on the order. On March 9, 2023, installation of EC-297540 was completed and the modification's PMT to close 759A was satisfactory.

Corrective Actions: The licensee initiated AR 2430592, Impact of 3-759A condition on EOP response; evaluated the effects on EOPs; identified the actions required to complete an alternate flow path via manipulations of valves to obtain a flow configuration for containment recirculation during cold leg injection; documented the alternate configuration on a Standing Operating Order; and reviewed the order with all the control room operators.

Corrective Action References: AR 2430592 and 2464946

Performance Assessment:

Performance Deficiency: The licensee's failure to evaluate the effects on the Unit 3 emergency operating procedures (EOPs) when RHR valve 3-759A was not able to close during execution of 3-EOP-ES-1.3, Revision 7, Transfer to Cold Leg Recirculation, was a performance deficiency.

Screening: The inspectors determined the performance deficiency was more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, during execution of 3-EOP-ES 1.3, which is used to transfer the RHR system from the RWST suction to containment sump suction for cold leg recirculation injection, if MOV-744A or B do not close, the RNO column requires manual valves 3-759A and B to be closed in order to complete the required configuration to initiate cold leg recirculation lineup from the containment. This action could not be completed due to 759A not being able to close.

Significance: The inspectors assessed the significance of the finding using IMC 0609 Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Using Exhibit 2, "Mitigating Systems Screening Questions," of IMC 0609, Appendix A, it was determined that this finding was of very low safety significance (Green) because "Yes" was not answered to any of the screening questions.

Cross-Cutting Aspect: P.2 - Evaluation: The organization thoroughly evaluates issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. The licensee did not thoroughly evaluate the effects on emergency operating procedures after valve 3-759A failed to close during surveillance testing.

Enforcement:

Violation: 10CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," requires that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformance's are promptly identified and corrected.

Contrary to the above, between February 07, 2021, and July 02, 2022, the licensee failed to promptly identify and correct a condition adverse to quality. Specifically, the licensee failed to promptly identify, evaluate and correct the impact to emergency operating procedure 3-EOP-ES-1.3, Revision 7, Transfer to Cold Leg Recirculation, when RNO to close RHR valve 3-759A could not be executed due to the valve's inability to close.

Enforcement Action: This violation is being treated as an NCV, consistent with Section 2.3.2 of the Enforcement Policy.

EXIT MEETINGS AND DEBRIEFS

The inspectors verified no proprietary information was retained or documented in this report.

- On August 17, 2023, the inspectors presented the biennial problem identification and resolution inspection results to Mr. Michael Pierce and other members of the licensee staff.

DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71152B	Corrective Action Documents	Action Requests	2426193, 2417691, 2402374, 2449777, 2388432, 2392790, 2399830, 2426904, 2408406, 2412932, 2456051, 2426986, 2388593, 2445264, 2435690, 2386603, 2406443, 2446963, 2402433, 2389971, 2390191, 2398661, 2408667, 2416494, 2426375, 2432955, 2440050, 2446953, 2386800, 2394547, 2402208, 2409504, 2412374, 2415394, 2425498, 2439323, 2454318, 2458358, 2451900, 2450051, 2464401, 2464687, 2461238, 2397388, 2315688, 2386531, 2430592, 2394472, 2461238, 2397388, 2420452, 2400314, 2451900, 2460645, 2386531, 2386531, 472943, 475987, 2405435, 2405435,	
71152B	Corrective Action Documents Resulting from Inspection	2463678	Coatings required on AFW pipe	
71152B	Corrective Action Documents Resulting from Inspection	2464156	Exhaust damper falling off	
71152B	Corrective Action Documents Resulting from Inspection	2464395	Add Structural Monitoring Program Form documentation from a previously evaluated AR	
71152B	Corrective Action Documents Resulting from Inspection	2464401	Corroded nuts at the base of column KBC36.1 (inside Unit 4 condensate storage tank cage)	
71152B	Corrective Action Documents Resulting from Inspection	2464715	Corrosion of 3A, 3B, & 3C ICW motor heater supports	
71152B	Corrective Action Documents	AR-PCR 2464687	Driving alignment on the guidance within ER-AA-100-2002, Maintenance Rule Program Administration	

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
	Resulting from Inspection			
71152B	Procedures	0-ADM-200	Operations Management Manual	47
71152B	Procedures	0-ADM-504	Corrosion Monitoring and Action Program	0
71152B	Procedures	0-OSP-200.5	Miscellaneous Tests, Checks and Operating Evolutions	66
71152B	Procedures	AD-AA-103	Nuclear Safety Culture Program	26
71152B	Procedures	ER-AA-100-2002	Maintenance Rule Program Administration	13
71152B	Procedures	OP-AA-108-1000	Operator Challenges Program Management	8
71152B	Procedures	OP-AA_100-1000	Conduct of Operations	39
71152B	Procedures	PI-AA-01	Corrective Action Program and Condition Reporting	4
71152B	Procedures	PI-AA-100-020	Condition Assessment and Response	20
71152B	Procedures	PI-AA-101	Assessment and Improvement Programs	33
71152B	Procedures	PI-AA-102	Operating Experience Program	20
71152B	Procedures	PI-AA-104-1000	Condition Reporting	39
71152B	Procedures	PI-AA-203	Action Tracking Management	18
71152B	Procedures	WM-AA-200	Work Management Process Overview	23
71152B	Procedures	WM-AA-201	Work Order Identification, Screening, and Validation Process	39
71152B	Self-Assessments		Nuclear Safety Culture Monitoring Panel Meeting Minutes	05/10/2022
71152B	Self-Assessments		Engineering Assessment	06/30/2021
71152B	Self-Assessments		Access Authorization Assessment	04/28/2021
71152B	Self-Assessments	AR-L2A 2437000	2022 Turkey Point Mid-Cycle Assessment	08/26/2022
71152B	Self-Assessments	PTN 21-007	Emergency Planning Audit	09/01/2021
71152B	Self-Assessments	PTN-21-006	Training Audit	08/26/2021
71152B	Self-Assessments	PTN-22-002	Radiation Protection	
71152B	Self-Assessments	PTN-22-004	Operations Audit	06/09/2022
71152B	Work Orders	WOs	4056596001, 4060507301, 4064637201, 4067676701	