VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY: (802) 241-0480
Survey and Certification Reporting Line (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 17, 2024

Mr. Chris Groves, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

RE: Complaint Survey Findings - Past Non-Compliance

Dear Mr. Groves:

On **May 29, 2024**, the Division of Licensing and Protection completed a complaint investigation at Burlington Health & Rehab. As a result of that survey, the Division determined that at a point in time prior to the date of our visit you were not in substantial compliance with the federal regulations applicable to long-term care facilities.

Statement of Deficiencies Form CMS 2567

Enclosed is a statement of deficiency generated as a result of the survey. All references to regulatory requirements in the enclosure and in this letter are found in Title 42, Code of Federal Regulations. As the cited deficiencies were corrected at the time of our visit, no plan of correction is required. Please **sign page 1 and return a signed copy of the 2567 to this office.**

The following Civil Money Penalties (CMP) have been recommended:

Per Instance CMP for F-600 Free From Abuse & Neglect - G $17,200.00
Per Instance CMP for F-684 Quality of Care - G $17,200.00

Informal Dispute Resolution (IDR) Opportunity

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, including an explanation of why you are disputing

those deficiencies, to Pamela Cota, RN, at the Division of Licensing and Protection. Contact information is listed below. Please include if you would prefer a virtual meeting or prefer to submit information in writing for review. This request must be sent during the same ten days you have for submitting your plan of correction. You must still submit a plan of correction for all deficiencies, including those you are disputing, by the due date. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. Please note that the following are not allowable disputes in the IDR process: scope and severity of deficiencies, unless they are immediate jeopardy level or constitute substandard quality of care; remedies imposed by CMS; survey process or inconsistency issues; or concerns about the IDR process.

Email (preferred): Pamela.Cota@vermont.gov
Mailing address: Division of Licensing and Protection, attn Pamela Cota
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
Phone: (802) 241-0480

Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475014	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLINGTON HEALTH & REHAB	300 PEARL STREET BURLINGTON, VT 05401

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of a facility reported incident (ACTS #23012) and a complaint (ACTS #23011) on 5/28/24, with additional offsite interviews on 5/29/24, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to protect the resident's right to be free from neglect for one applicable resident (Resident #1) by neglecting to provide services that are necessary to avoid physical harm and emotional distress related to providing care to a port (port-a-cath; a device, typically implanted in the chest, used to access the central vein to deliver medications or obtain blood samples) for	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 6/17/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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1 applicable resident (Resident #1). As a result, Resident #1's port became infected and had to be removed which delayed Resident #1's chemotherapy. Findings include:

Per record review, Resident #1 was admitted to the facility on 4/3/2024 and has diagnoses that include ovarian cancer, congestive heart failure, and depression. A 4/3/24 facility nurse Practitioner note indicates that Resident #1 was admitted for sub-acute rehabilitation from the hospital following 3 rounds of chemotherapy and surgery to remove her uterus, ovaries, and tumors related to ovarian cancer. The note indicates that she will need additional rounds of chemotherapy in the future. A 4/29/24 hospital oncology physician visit note reveals that Resident #1's treatment plan is to receive her fourth dose of chemotherapy on 5/10/24.

Per phone interview on 5/29/24 at 10:35 AM, Resident #1's Representative explained that when Resident #1 went to their appointment on 5/10/24 to receive their fourth round of chemotherapy, the staff identified that her port was infected. Resident #1 had their port removed, was admitted to the hospital and was unable to receive their fourth round of chemotherapy. The Representative explained that s/he was there at the chemotherapy appointment and stated the staff "removed a blue ...moldy or fungus" looking bandage and described the site as red and inflamed and described the port site as black. The Representative stated that Resident #1 is still in the hospital, has not had her port replaced, and has not been able to receive her fourth dose of chemotherapy which has made her upset and very anxious.

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A hospital outpatient chemotherapy Registered Nurse note dated 5/10/24 states that "I went to remove the gauze and Tegaderm [adhesive dressing which can be used for up to seven days] over the patient's port site and I found the gauze to be dried [with a] blackish colored substance. Her port site itself appeared ecchymotic [discolored skin resulting from ruptured blood vessels], tender, swollen and a black scab was present. [Patient] reports that it has 'itched.' She denies any fevers. Her [white blood count] is elevated. She is unsure if this dressing has ever been changed to the site assessed since her admission to Rehab [facility]. . . Plan to hold chemo today, have [radiology] assess the port site and admit patient for observation and antibiotics and likely port removal. Patient is upset/anxious but able to reassure patient."

Included in the above notes are two photos of Resident #1's port site. The first photo reveals Resident #1's port site which appears to be approximately 1.5 cm x 1.5 cm, raised, and very red with a pinhole open black spot. The second photo shows the gauze that was removed from the port site being approximately 2.5 cm x 2.5 cm and covered in a black-ish substance. A hospital physician history and physical note dated 5/10/24 explains that Resident #1's chemotherapy was deferred today and she "reports feeling like her whole body is achy," and say the port "has been tender for 'awhile.'" Physical exam findings reveal the chest is "erythematous port site with pinhole at 6 o'clock. No active drainage, mildly tender to palpation." A hospital Physician progress note dated 5/14/24 reveals that "[Resident #1] presents as a direct admit from the chemotherapy infusion suite, where she was found to have an infected port prior to her fourth cycle of

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chemotherapy. . . Infected port removed, now [status post] vancomycin (5/10-5/13) [antibiotic]. Decided to hold on port replacement yesterday given patient's fragility and pending chemotherapy break."

Per phone interview on 5/29/24 at 11:01 AM, the hospital outpatient chemotherapy Registered Nurse (HRN #1), who wrote the above note, confirmed that the above nursing note was accurate. Per phone interview on 5/29/24 at 4:38 PM, a second hospital outpatient chemotherapy Registered Nurse (HRN #2) explained that on 5/10/24 Resident #1's port appeared to be infected. HRN #2 reviewed Resident #1's hospital medical record and confirmed that the port was not accessed at the hospital, including the two outpatient visits she had on 4/11/24 and 4/29/24, since 4/3/24. HRN #2 explained that the dressing that Resident #1 had covering her port was not intended to be on for an extended period of time. S/He explained that since Resident #1's port was over 2 weeks old when she arrived at the nursing facility on 4/3/24, the expectation would be for the dressing to be removed on admission to the facility so the port could be assessed and not cover the port again. S/He explained that the expectation of the facility would be to monitor the port site regularly without a dressing to notice any potential complications.

Per interview on 5/28/24 at approximately 9:10 AM, the Director of Nursing (DON) explained that the hospital contacted the facility on 5/10/24 to let them know Resident #1 would not be returning to the facility because she was being admitted to the hospital. The DON explained that the facility initiated an investigation and discovered that Resident #1 had an infected port.

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There is no evidence that Resident #1's port was identified on admission to the facility on 4/3/24.

While the Transfer of Care (hospital discharge summary) dated 4/3/24 does not reveal that Resident #1 has a port or any physician orders to care for Resident #1's port, the facility did not identify the port on the admission nursing assessment. Per the initial admission nursing assessment completed on 4/3/24, Resident #1's port is not identified, including the section that assesses for a port, "device/treatment," and skin status, "Integumentary."

Per interview on 5/28/24 at 8:55 AM, a Unit Manger explained that on admission, a floor nurse will do the initial nursing assessment using an admission checklist. The facility tries to get the wound nurse to do the skin assessment with the floor nurse to identify any possible skin issues, including those that are not on the transfer of care document. The admission check list provided to this surveyor by the Unit Manager shows a section for IVs, PICC lines, and ports (devices inserted into the body used to deliver medications) with a checklist to obtain batch provider orders (dressing change, measurements, etc.) and a care plan.

Per interview on 5/28/24 at 8:50 AM, Licensed Practical Nurse (LPN) #4 explained that if a resident had a port, nursing staff would need physician orders to remove or change a dressing, provide port care, and would also have an order to monitor the port site.

A review of the facility investigation reveals the following transcripts of interviews conducted by

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facility leadership with staff. On 5/13/24 at 2:30 PM, the Licensed Practical Nurse (LPN #1) who documented and signed as preforming Resident #1 admission nursing assessment, including a comprehensive skin check, explained that s/he did not see the dressing on Resident #1's chest on admission because the only contact s/he had with Resident #1 was to give her medications and RN #1 did the skin assessment. LPN #1 states that s/he does recall Resident #1 having a dressing on her chest, but not until 5/7/24. On 5/14/24 at 4:15 PM, Registered Nurse (RN #1) who is the facility's lead skin nurse explains that s/he does not remember seeing gauze dressing or a port when s/he assessed Resident #1 on admission.

Because the port was not identified on admission, Resident #1 did not receive physician orders to care for the port, including orders for dressing changes, and a care plan focus related to risk of infection related to a port, with interventions that include monitoring the port.

After admission, there is no evidence that direct care staff provided Resident #1's services to prevent complications of her port at any time between 4/3/24 and 5/10/24. The staff neglected to complete comprehensive skin assessments, document the port, obtain care orders for the port, develop a plan of care for the port, provide care to the port, and monitor the port site for complications.

Per review of weekly skin assessments completed by RN #2 on 4/17/24 and 5/1/24 and review of all Resident #1's nursing notes, there is no evidence that RN #2 was aware of Resident #1's port. Per a transcript of an interview

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conducted by facility leadership with RN #2 on 5/13/24 at 3:52 PM, RN #2 explained that s/he did not know Resident #1 had a port because s/he did not look at Resident #1's entire skin during skin assessments. Per interview on 5/28/2024 at 11:43 AM, RN #2 explained Resident #1's port should have been discovered and documented during weekly skin assessments and confirmed that skin assessments are to be a head to toe inspection of a resident's body.

The following transcripts of interviews conducted by facility leadership with staff reveal that multiple licensed nurses were aware that Resident #1 did have a port. On 5/13/24 at 2:20 PM, LPN #4, who completed Resident #1's skin checks on 4/10/24 and 4/24/24, said s/he was aware that Resident #1 had a port under her dressing but was told by the skin lead nurse that oncology was addressing it. On 5/13/24 at 2:48 PM, LPN #2, said s/he was aware that Resident #1 had a dressing and figured people knew about it. On 5/13/24 at 2:54 PM, LPN #3, who completed Resident #1's skin check on 5/1/24, explained that Resident #1 had a chemo port under a dressing on her chest and didn't take off the dressing to look at the port. LPNs #2, #3, and #4 do not indicate in these interviews that they removed the dressing in order to monitor Resident #1's port site.

Along with the weekly skin checks completed by licensed nursing staff on 4/10/24, 4/17/24, 4/24/24, 5/1/24, and 5/8/24, care documented in the POC (point of care; electronic documentation system for Licensed Nursing Assistants) shows that Licensed Nursing Assistants (LNAs) had multiple opportunities to observe Resident #1's entire skin, including the dressing covering Resident #1's port. Showers are documented as

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given on 4/10/24, 4/19/24, 4/22/24, 4/26/24, 4/30/24, and 5/7/24 and bed baths are documented as given on 4/3/24, 4/4/24, 4/7/24, 4/8/24, 4/13/24, 4/18/24, 4/20/24, 4/21/24, 4/25/24, and 5/2/24.

The following transcripts of interviews conducted by facility leadership with staff reveal that the LNAs were aware of the bandage on Resident #1's chest and had discussed it with nursing staff.

On 5/13/24 at 1:15 PM LNA #1 stated that s/he had given Resident #1 approximately 3 showers and remembers seeing a dressing on her chest and nursing staff had told him/her that it as ok to shower the resident as long as they covered the dressing. On 5/13/24 at 2:05 PM LNA #2 stated that s/he had given Resident #1 a shower shortly after she was admitted to the facility and remembers seeing a dressing on Resident #1's chest and being told by nursing staff that s/he could cover up the dressing for the shower.

While interviews reveal that multiple direct care staff were aware that Resident #1 had a port there is no evidence that anyone provided any care to the port. Per review of Resident #1's medical record, including nursing assessments, skin assessments, nursing notes, provider notes, physician orders, care plan, Medication Administration Records, and Treatment Administration Records, Resident #1's port was not documented and there is no evidence that their port was cared for or monitored for 38 days, the entirety of their stay at the facility.

Per a transcript of an interview conducted by facility leadership with the Unit Manager (UM) on 5/13/24 at 2:54 PM, the UM confirmed that staff

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did not make him/her aware that Resident #1 had a port.

Per interview on 5/28/24 at 1:25 PM with the DON and the Market Clinical Lead, the Market Clinical Lead confirmed that there was no documentation that the staff monitored the port site or that staff had contacted the DON or a provider to obtain care orders for the port at any time during Resident #1's stay at the facility. The DON explained that no staff had come to him/her to address that Resident #1 did not have any care orders or a care plan for their port and confirmed that s/he did not know that Resident #1 had a port until she was admitted to the hospital following her chemotherapy appointment on 5/10/24 and stated that s/he should have been aware.

Per review of the facility investigation, a document titled "Plan of Action" states "Based on the investigation the facility noted the following:
1) Admission assessment should have included removing the protective dressing over the port site and identify the port on admission
2) The facility should have initiated orders for care of the port
3) The facility should have a [care plan] for care of the port"
The above was confirmed by the Market Clinical Director on 5/28/2024 at 1:25 PM.

****

Per review of a facility "Plan of Action" and interview on 5/28/24 at 1:25 PM, the Director of Nursing (DON) and the Market Clinical Lead revealed that the facility implemented corrective action for the above deficiency. The facility completed a house wide audit of skin on 5/11/24 to ensure all ports were identified and no

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F 600	Continued From page 9 residents were identified to have ports. Education related to skin assessments, wound dressings, port dressing changes, and obtaining care orders for the port, and care planning for the port, completed on 5/15/24. The DON or designee will audit all new admissions for ports and audits will be reviewed at monthly QAPI meetings. Based on corrective actions completed by 5/15/24, prior to the onsite investigation, this citation is designated as past non-compliance. Reference regarding Tegaderm: https://multimedia.3m.com/mws/media/2243525O/nexcare-tegaderm-transparent-dressing.pdf	F 600		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide care to a port ["A port protects your veins during cancer treatment. An implanted port is a type of central venous catheter ...[that] lets the medication go into your bloodstream through your vein. It can be used to give you medication for several days in a row.1."] for 1 applicable resident (Resident #1) as evidenced by staff not conducting comprehensive skin	F 684	Past noncompliance: no plan of correction required.	

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assessments, obtaining and implementing orders for port care, and care planning for the care of a port. As a result, Resident #1's port became infected and had to be removed which delayed Resident #1's chemotherapy. Findings include:

Per record review, Resident #1 was admitted to the facility on 4/3/2024 for sub-acute rehabilitation following abdominal surgery and has diagnoses that include ovarian cancer, congestive heart failure, and depression. A 4/3/2024 facility nurse practitioner note indicates that Resident #1 was admitted for sub-acute rehabilitation from the hospital following three rounds of chemotherapy, surgery to remove her uterus, ovaries, and tumors related to ovarian cancer. The note indicates that she will need additional rounds of chemotherapy in the future. A 4/29/24 hospital oncology physician visit note reveals that Resident #1's treatment plan is to receive her fourth dose of chemotherapy on 5/10/24.

A telephone interview was conducted 05/29/2024 at 10:35 AM with Resident #1's family representative who was present at the chemotherapy infusion appointment. The family representative discussed that when Resident #1 went to their appointment on 5/10/24 to receive their fourth round of chemotherapy, she instead was admitted to the hospital because of an infected port and was unable to receive their fourth round of chemotherapy. The family representative stated the staff "removed a blue ...moldy or fungus" looking bandage. The family representative described the site as red and inflamed and described the port site as black. The medical team consulted with Oncology and admitted Resident #1 to the hospital that day [05/10/2024]. She did not have chemotherapy

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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that day. IR (Interventional Radiology) removed the old port. The family representative discussed but they have not put a new port in yet and have thus not received any chemotherapy. The family representative discussed that Resident #1 is upset and anxious about her delayed chemotherapy.

A hospital outpatient chemotherapy Registered Nurse note dated 5/10/24 states that "I went to remove the gauze and Tegaderm [adhesive dressing which can be used for up to seven days] over the patient's port site and I found the gauze to be dried [with a] blackish colored substance. Her port site itself appeared ecchymotic [discolored skin resulting from ruptured blood vessels], tender, swollen and a black scab was present. [Patient] reports that it has 'itched.' She denies any fevers. [His/Her] [white blood count] is elevated. She is unsure if this dressing has ever been changed to the site assessed since her admission to Rehab [facility]. . . Plan to hold chemo today, have [radiology] assess the port site and admit patient for observation and antibiotics and likely port removal. Patient is upset/anxious but able to reassure patient." Included in the above notes are two photos of Resident #1's port site. The first photo reveals Resident #1's port site which appears to be approximately 1.5 cm x 1.5 cm, raised, and very red with a pinhole open black spot. The second photo shows the gauze that was removed from the port site being approximately 2.5 cm x 2.5 cm and covered in a black-ish substance. A hospital physician history and physical note dated 5/10/24 explains that Resident #1's chemotherapy was deferred today and she "reports feeling like her whole body is achy," and say the port "has been tender for 'awhile.'" Physical exam findings reveal

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	475014	A. BUILDING _____ B. WING _____	C 05/29/2024

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the chest is "erythematous port site with pinhole at 6 o'clock. No active drainage, mildly tender to palpation." A hospital Physician progress note dated 5/14/24 reveals that "[Resident #1] presents as a direct admit from the chemotherapy infusion suite, where she was found to have an infected port prior to her fourth cycle of chemotherapy. . . Infected port removed, now [status post] vancomycin (5/10-5/13) [antibiotic]. Decided to hold on port replacement yesterday given patient's fragility and pending chemotherapy break."

Per phone interview on 5/29/24 at 4:38 PM, a hospital outpatient chemotherapy Registered Nurse (HRN #2) explained that on 5/10/24 Resident #1's port appeared to be infected. HRN #2 reviewed Resident #1's hospital medical record and confirmed that the port was not accessed at the hospital, including the two outpatient visits she had on 4/11/24 and 4/29/24, since 4/3/24. HRN #2 explained that the dressing that Resident #1 had covering her port was not intended to be on for an extended period of time. S/He explained that since Resident #1's port was over 2 weeks old when she arrived at the facility on 4/3/24, the expectation would be for the dressing to be removed on admission to the facility so the port could be assessed and not cover the port again. S/He explained that the expectation of the facility would be to monitor the port site regularly without a dressing to notice any potential complications.

While the Transfer of Care (hospital discharge summary) dated 4/3/24 does not reveal that Resident #1 has a port or any physician orders to care for Resident #1's port, the facility did not identify the port on the admission nursing

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assessment. Per the initial admission nursing assessment completed on 4/3/24, Resident #1's port is not identified, including the section that assesses for a port, "device/treatment," and skin status, "Integumentary."

Per record review the DON and Market Clinical Lead investigated the concern of resident #1's port. The investigation included transcripts of interviews conducted with staff involved with Resident #1's care from 4/3/24 to 5/10/24. Some interviews reveal that staff did not perform complete skin assessments to identify Resident #1's port. A majority of the interviews conducted with multiple direct care staff reveal that they were aware that Resident #1 had a port but did not provide any care to the port, including dressing changes or monitoring the port site under the bandage.

Per review of Resident #1's medical record, including nursing assessments, skin assessments, nursing notes, provider notes, physician orders, care plan, Medication Administration Records, and Treatment Administration Records, Resident #1's port was not documented and there is no evidence that their port was cared for or monitored for 38 days, the entirety of their stay at the facility.

Per a comprehensive record review revealing zero evidence that port care was performed, including comprehensive skin assessments, obtaining and implementing orders for port care, and care planning for the care of a port, in combination with review of the facility investigation related to Resident #1's port care, the facility neglected to provide care for Resident #1's port. See F600 for more information.

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Per interview on 5/28/24 at 1:25 PM with the DON and the Market Clinical Lead, the Market Clinical Lead confirmed that there was no documentation that the staff monitored the port site or that staff had contacted the DON or a provider to obtain care orders for the port at any time during Resident #1's stay at the facility. The DON explained that no staff had come to him/her to address that Resident #1 did not have any care orders or a care plan for their port and confirmed that s/he did not know that Resident #1 had a port until she was admitted to the hospital following her chemotherapy appointment on 5/10/24 and stated that s/he should have been aware.

A facility investigation Plan of Action states "Based on the investigation the facility noted the following:
1) Admission assessment should have included removing the protective dressing over the port site and identify the port on admission
2) The facility should have initiated orders for care of the port
3) The facility should have a [care plan] for care of the port"
The above was confirmed by the Market Clinical Director on 5/28/2024 at 1:25 PM.

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Per review of a facility "Plan of Action" and interview on 5/28/24 at 1:25 PM, the Director of Nursing (DON) and the Market Clinical Lead revealed that the facility implemented corrective action for the above deficiency. The facility completed a house wide audit of skin on 5/11/24 to ensure all ports were identified and no residents were identified to have ports. Education

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F 684	Continued From page 15 related to skin assessments, wound dressings, port dressing changes, and obtaining care orders for the port, and care planning for the port, completed on 5/15/24. Based on corrective actions completed by 5/15/24, prior to the onsite investigation, this citation is designated as past non-compliance. 1. Reference: "About Your Implanted Port." Memorial Sloan Kettering Cancer Center. https://www.mskcc.org/cancer-care/patient-education/your-implanted-port	F 684		