Rhode Island: IJ

CMS Survey

Medication Administration Errors and Training Deficiencies Lead to Critical Hypoglycemic Event

Overview[1]

Centers for Medicare & Medicaid Services (CMS) Inspection Survey

Level of harm

IJ: Immediate jeopardy to resident health or safety

Setting

- **165** certified beds[2]
- **114** residents/day, on average[2]
- **3.77** nurse hours/resident/day[2]

Facility star rating

Before incident (2/29/2024)[3]

Post (as of 9/26/2024)[4]

Patient history[1]

- Admitted for short-term rehab.
- Diagnosed with diabetes requiring insulin aspart 40 units subcutaneously daily at 11 am and insulin aspart protamine/insulin aspart 70/30 36 units subcutaneously daily at bedtime.
- Instructions to **withhold insulin** if blood glucose **(BG) <200 mg/dL.**
- Chart documented physician's **order on 3/7/2024 for glucagon emergency kit** 1 mg intramuscularly as needed for hypoglycemic reaction for BG <60.

Timeline of events[1]

Incident date 3/7/2024

Incident timeline (11 AM – 11:21 PM)

11:00 AM
BG 138. Failing to see the "hold" parameter in the chart, Nurse A administered 40 units insulin aspart.

5:30 PM
Resident was found unresponsive, Code Blue called. Oxygen saturation dropped to 88%; resident was placed on non-rebreather at 15L; BG 31*.

Complaint date 3/8/2024

5:40 PM
Nurse B attempted to administer glucagon 1 mg from vial and called 911.

5:48 PM
Staff re-checked BG; reading was 34. Nurse C retrieved, mixed, and administered a second dose of glucagon.

Between 5:48 and 5:55 PM
EMS arrived. BG 38. EMS administered IV dextrose 10; re-check BG was 78. EMS administered supplemental oxygen.

Complaint survey completion date 3/15/2024

5:55 PM
Resident was transported to ER by EMS; BG en route was 168 and improved to 190s on arrival.

11:21 PM
Resident was admitted to hospital with diagnosis of altered mental status.

BG, blood glucose; EMS, emergency medical services; ER, emergency room; IV, intravenous.
*Normal blood sugar range is between 70 and 125 milligrams/deciliter (mg/dL).[1]

xeris® PHARMACEUTICALS

Investigation findings[1]

Issues with electronic health record usability

Two nurses reported that insulin "hold" parameters were not visible on the main screen and they had to manually "hover" over the order to see the instruction to withhold if blood sugar was <200 mg/dL. As a result, on four separate days, the resident received insulin despite a BG <200 mg/dL (dates: 3/3, 3/4, 3/6, 3/7).

Medication error

Nurse C noticed the glucagon bottle Nurse B pulled to administer still had glucagon powder in the vial. Once they realized the glucagon was not administered, they decided to pull and administer a second dose. Nurse B acknowledged he/she was unaware they needed to reconstitute the glucagon and only injected sterile water.

Lack of competency training

Nurse B revealed he/she had not received any trainings or competencies for the use of glucagon. The Director of Nursing (DON) indicated they would have expected Nurse B to give the correct dose of glucagon by reconstituting the medication as required. The DON was unable to provide evidence that Nurse B received any training and/or competencies related to the reconstitution and administration of glucagon. An expanded review of personnel files for Nurses A, D, E, and F also failed to reveal evidence of competencies related to the reconstitution and administration of glucagon.

Outcomes[1]

For the resident

Deficiencies caused critical hypoglycemia (BG 31) and hypoxia (O_2 <90%) requiring a non-rebreather mask, EMS intervention, IV dextrose, and subsequent hospitalization for altered mental status.

For the LTC facility

Two "Immediate Jeopardy" citations indicated substandard quality of care, adding to a pattern of non-compliance that potentially damaged the facility's reputation and star rating.[1,2,5]

Financial burden

While specific costs were not documented, adverse events may often be associated with broader financial consequences.

F 0760: Residents are free of significant medication errors[1,2,5]

The facility failed to ensure that the residents are free from significant medication errors for 1 of 2 residents reviewed who received insulin.

F 0726: Competent nursing staff[1,5]

Nurses did not have the appropriate competencies to care for every resident in a way that maximizes each resident's well-being. The facility did not ensure that licensed nurses were trained in the necessary skills to administer glucagon that required reconstitution before injection.

Severity

Immediate jeopardy to resident health or safety

Scope

Few people affected

Seriousness

IJ

Scan to explore more public records on severe hypoglycemic events and emergency preparedness across long-term care facilities.

For additional guidance on best practices, connect with your LTC Territory Managers.

References: 1. Centers for Medicare & Medicaid Services. Nursing home complaint inspection report. Medicare.gov. March 15, 2024. Accessed January 31, 2026. medicare.gov/care-compare/inspections/pdf/nursing-home/415129/health/complaint-inspection?date=2024-03-15. **2.** ProPublica. Nursing home inspection report. November 2025. Accessed January 31, 2026. projects.propublica.org/nursing-homes/homes/h-415129. **3.** Centers for Medicare & Medicaid Services. Nursing homes including rehab services archived data snapshots. February 2, 2024. Accessed January 29, 2026. data.cms.gov/provider-data/archived-data/nursing-homes. **4.** Centers for Medicare & Medicaid Services. Nursing homes including rehab services archived data snapshots. September 26, 2024. Accessed February 20, 2026. data.cms.gov/provider-data/archived-data/nursing-homes. **5.** Centers for Medicare & Medicaid Services. List of revised F-Tags. April 2025. Accessed January 27, 2026. cmscompliancegroup.com/wp-content/uploads/2025/05/List-of-Revised-FTags-04282025.pdf.