Care CEUs

Diabetes Management

1. According to the course, which description best captures the biological difference between Type 1 and Type 2 diabetes and how that difference shapes care planning in older adults?

A. Type 1 diabetes is caused by age-related insulin resistance in muscle and fat, whereas Type 2 results from autoimmune destruction of beta cells; both are managed primarily by diet without a predictable need for insulin therapy.
B. Type 1 diabetes is an autoimmune "supply problem" in which the pancreas stops making insulin, whereas Type 2 diabetes is an "access problem" in which cells become resistant to insulin; care plans must therefore assume lifelong insulin replacement in Type 1, but focus on reducing insulin resistance and tailoring lifestyle and medications in Type 2.
C. Both Type 1 and Type 2 diabetes are primarily caused by hormonal shifts during pregnancy, and in older adults they are usually reversible with short-term dietary restriction and exercise alone.
D. Type 1 diabetes results from gradual pancreatic burnout in old age, while Type 2 is an autoimmune disorder seen almost exclusively in children, so geriatric care plans rarely need to address insulin therapy.

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2. In a long-term care facility where residents mirror the national demographics of adults over 65, which resource-planning approach best reflects the course's data and recommendations about diabetes in this population?

A. Plan for roughly one in three residents to require specialized carbohydrate-monitored menus, complex medication and insulin timing, and frequent skin and foot assessments with high-level nursing surveillance, because about 33% of adults over age 65 are living with diabetes.
B. Assume fewer than 10% of residents will have diabetes and focus primarily on annual A1C screening, with little need for dedicated dietary or skin-surveillance resources.
C. Expect diabetes to be rare in skilled nursing but common in assisted living, so direct nearly all diabetes-related staffing and dietary resources to the assisted living side.
D. Allocate resources mainly to short-stay rehabilitation residents, because long-stay geriatric residents typically have stable blood sugars and minimal need for specialized monitoring.

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3. Your facility has seen several diabetes-related lower-extremity amputations in the past year. Based on the course, which systems change would most directly target the underlying causes and reduce this risk?

A. Standardize the use of rigid, tightly fitting shoes to stabilize the foot, assuming that firmer footwear will prevent the friction and pressure that lead to diabetic ulcers.
B. Focus primarily on treating wounds after they appear by applying topical antibiotic ointments and leaving ulcers open to air so they can "dry out" and scab over.

C. Prioritize annual vascular imaging for all residents with diabetes while leaving routine foot checks to residents and families, since pain will alert them to serious problems.
D. Implement structured daily foot inspections for at-risk residents, early podiatry referral, aggressive off-loading of pressure, and tight blood glucose control, recognizing that painless neurotrophic ulcers driven by neuropathy and poor circulation precede most amputations.

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4. An 82-year-old man with long-standing Type 2 diabetes and severe neuropathy develops a round, "punched-out" ulcer under the ball of his foot, surrounded by a hard callus. He denies pain, and his peripheral pulses are still palpable. According to the course, how is this wound best classified?

A. An arterial (ischemic) ulcer caused by severe peripheral arterial disease, typically very painful and non-bleeding with pale surrounding skin.
B. A neurotrophic (diabetes-related) ulcer caused by systemic nerve damage and abnormal pressure points on the plantar surface of the foot.
C. A venous leg ulcer caused by venous insufficiency, usually shallow with uneven edges and located in the gaiter region between mid-calf and ankle.
D. A classic pressure ulcer over a bony prominence, primarily due to prolonged immobility rather than neuropathy or vascular disease.

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5. A resident with Type 2 diabetes has lost weight and complains that his rigid 'diabetic diet' has taken all the joy out of eating. Based on the course's 'Food is Medicine' and liberalized diet discussion, which nutrition strategy best balances glycemic control with quality of life?

A. Tighten restrictions further by eliminating all desserts and most fruits, relying heavily on calorie-dense supplements and bland therapeutic menus to ensure he meets numeric nutrition targets.
B. Remove all diabetes-related restrictions and allow him unlimited access to sugary drinks, white bread, and sweets to restore enjoyment of food, while depending on sliding-scale insulin to manage blood sugars.
C. Work with a dietitian to create a liberalized, person-centered plan emphasizing high-fiber, nutrient-dense carbohydrates (such as non-starchy vegetables and minimally processed starches), lean proteins, and appealing meals, allowing occasional sweets while avoiding daily refined sugars and highly processed foods.
D. Place every resident, regardless of diagnosis, on a uniform ultra–low-carbohydrate diet so that kitchen operations are simplified and blood sugars are controlled through restriction alone.

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6. You are designing an exercise program for residents with diabetes who use insulin. According to the course, which set of instructions best reflects evidence-based guidance for safe physical activity in this group?

A. Encourage exercise 1–3 hours after meals when blood sugar is typically highest, check glucose before and for up to 6–12 hours after strenuous activity, provide a small snack if pre-exercise glucose is below 100 mg/dL, and have residents carry glucose tablets or hard candy and wear a medical alert bracelet.

B. Schedule exercise first thing in the morning in a fasting state, discourage blood sugar checks around activity, and rely on staff observation alone to detect symptoms of hypoglycemia.
C. Limit residents with diabetes to light stretching only and avoid aerobic or resistance training, because these forms of exercise do not significantly affect A1C or cardiovascular risk.
D. Recommend that residents exercise vigorously only when their blood sugar is very low, so that activity can quickly raise glucose levels without the need for snacks or monitoring.

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7. The course presents two contrasting scenarios involving Mr. Miller, a 78-year-old with Type 2 diabetes, where hypoglycemia is either caught early or leads to a hip fracture and a "Failure to Monitor" citation. From an administrative standpoint, which intervention most directly addresses the root difference between these outcomes?

A. Purchasing additional glucometers and requiring nurses to perform scheduled finger-stick testing only at fixed times, without involving non-clinical staff in observation or reporting.
B. Building a zero-barrier communication culture in which all departments are trained to recognize subtle red flags of hypoglycemia (such as a missed meal, confusion, pallor, or sweating) and are explicitly encouraged to report any concern immediately, reinforcing that there is no such thing as a nuisance observation.
C. Limiting access to outdoor areas like the garden so that residents with diabetes are kept under closer visual supervision, even if this restricts their autonomy and quality of life.
D. Instructing non-clinical staff to report concerns only if a resident verbalizes classic symptoms like "I feel like my sugar is low," to prevent overloading nurses with minor observations.

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8. You are planning a mandatory diabetes in-service for all departments. According to the training suggestions in the course, which format is most likely to build practical "muscle memory" and interdepartmental teamwork around recognizing and responding to hypo- and hyperglycemia?

A. Distribute printed handouts summarizing diabetes complications and instruct staff to review them independently during downtime, without structured discussion or practice.
B. Hold a traditional lecture in which a nurse leader reads the facility’s diabetes policy word-for-word while the rest of the staff listens and signs an attendance sheet.
C. Run an Interactive Response Challenge by forming cross-departmental teams, giving each a hypoglycemia or hyperglycemia scenario, having them discuss "What do you see, and what do you do?" then presenting their action plans to the group and debriefing with a standardized symptom chart.
D. Show a pre-recorded webinar to each department separately, focusing solely on laboratory targets and medication names, with no opportunity for questions or scenario-based practice.

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9. During a survey, inspectors discover that a resident with diabetic neuropathy has a necrotic plantar foot ulcer that was not identified through routine facility checks; there is no documentation of regular foot inspections or off-loading despite clear risk factors. Based on the course’s discussion of F-Tags, which primary citation is most directly implicated?

A. F-941, for failure to provide appropriate life-safety code training regarding fire drills and emergency evacuation procedures.

B. F-800, for failure to provide a palatable and attractive diet that meets each resident's food preferences and cultural needs.
C. F-759, for generic medication errors unrelated to wound prevention, such as missed routine oral medications.
D. F-686, for failure to maintain skin integrity and implement adequate preventative and monitoring measures for high-risk residents, including those with diabetes-related neuropathy.

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10. Your QAPI committee wants to prioritize performance measures that will reduce the risk of an Immediate Jeopardy–level F-684 (Quality of Care) citation related to diabetes. According to the course, which monitoring focus would best align with this goal?

A. Regularly auditing the timeliness and accuracy of blood glucose monitoring, the response to values outside pre-established parameters (including prompt clinical interventions), and documentation of physician notification when significant changes occur.
B. Tracking the number of low-carbohydrate menu items offered at each meal, without linking this information to individual care plans or blood glucose outcomes.
C. Measuring staff satisfaction with the electronic health record interface, assuming happier staff will indirectly reduce clinical errors without targeting any diabetes-specific processes.
D. Monitoring average resident length of stay, using this as the primary indicator of diabetes care quality regardless of complication rates or glycemic control.

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