CNA Exam Florida Practice Test PDF

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1. A Florida CNA has completed the required medication-administration training and has been found competent, but an RN has not delegated a medication task to the CNA. What should the CNA do?

A. Administer the medication because the CNA completed training

B. Administer the medication if the resident requests it

C. Do not administer it until the task is properly delegated

D. Ask a family member to administer it

Answer: C. Do not administer it until the task is properly delegated

A Florida CNA who has completed medication-administration training and been found competent should not administer medication until an RN properly delegates the task.

In Florida, a CNA may assist with medication only after completing the required training, being found competent, and having the task delegated by a licensed nurse such as an RN. Training and competency alone do not authorize the task; the delegation step is what places the task within the CNA's scope for that resident and situation. Until the RN delegates, the CNA should not give the medication and should clarify the assignment with the supervising nurse. This protects the resident from medication errors and protects the CNA from practicing outside the authorized scope.

A) Training alone authorizes administration

Completing training and being found competent are necessary steps, but they are not the final step. It can seem logical that finishing the course means the CNA can now give medications, yet delegation by the RN is still required before the task can be performed.

B) Administer if the resident requests it

A resident's request does not create authority to give medication. This option is tempting because CNAs want to be responsive to residents, but medication administration must follow the delegation and orders process, not a resident's preference.

D) Ask a family member to administer it

Family members are not authorized to give medications in a facility setting, and asking them to do so would bypass the care team's responsibility. This may seem like a way to meet the resident's need, but it creates safety and legal risks and does not follow proper delegation.

Conclusion

Remember that training and competency are only part of the process; an RN's delegation is what allows a Florida CNA to perform a medication task. When delegation has not occurred, the safe and correct action is to hold the task and notify the supervising nurse.

2. A resident begins to slide forward in a wheelchair while the CNA is providing care. What should the CNA do?

A. Leave the resident to get another task completed

B. Support the resident safely and obtain assistance if needed

C. Pull the resident upward by the arms

D. Tell the resident to slide farther forward

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Answer: B. Support the resident safely and obtain assistance if needed

The CNA should support the resident safely and obtain assistance if needed.

When a resident starts sliding forward in a wheelchair, the immediate priority is to keep the resident from falling or hitting the floor. The CNA should steady the resident, use good body mechanics, and lower or guide the resident to a safe position while calling for help if the resident cannot be moved safely alone. This protects both the resident and the CNA from injury and stays within the CNA's scope of practice.

A) Leave the resident to get another task completed

Leaving a resident who is sliding is dangerous because the resident could fall and be seriously injured in the time it takes to walk away. It may seem efficient to quickly finish another task, but resident safety always comes first, and the CNA should never leave a resident in an unstable position.

C) Pull the resident upward by the arms

Pulling a resident up by the arms can injure the resident's shoulders and skin and can also strain the CNA's back. This option may seem like a quick fix, but it is unsafe and does not use proper body mechanics or a gait belt.

D) Tell the resident to slide farther forward

Encouraging the resident to slide farther forward increases the risk of a fall and possible injury. This choice may seem like a way to reposition the resident, but it moves the resident toward the edge of the chair and away from safety.

Conclusion

Remember that when a resident is sliding or unstable, the CNA's job is to support the resident safely and get help rather than leave, pull on limbs, or encourage more sliding. Keeping the resident safe and using proper technique protects everyone involved.

3. When should a CNA perform hand hygiene when moving from one resident-care activity to another?

A. Only at the beginning of the shift

B. Only when hands look dirty

C. Whenever indicated by standard infection-control practices, including after contact with body fluids and between resident-care activities

D. Only after removing a gown

Answer: C. Whenever indicated by standard infection-control practices, including after contact with body fluids and between resident-care activities

Hand hygiene should be performed whenever standard infection-control practices indicate it, including after contact with body fluids and between resident-care activities.

Hand hygiene is the single most important way to prevent the spread of infection in a care setting. A CNA moves between residents and between tasks many times each shift, and hands can pick up germs even when they look clean. Standard infection-control practices guide when to clean hands, such as before and after resident contact, after touching body fluids or soiled items, after removing gloves or a gown, and when moving from one resident-care activity to another. Cleaning hands at these moments protects both the resident and the CNA.

A) Only at the beginning of the shift

Hands become contaminated many times during a shift, so cleaning them once at the start leaves germs spreading between residents and tasks for hours. This option may seem appealing because it sounds like a simple routine, but it does not match the ongoing nature of infection control.

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B) Only when hands look dirty

Many germs are invisible, so hands can carry infection even when they appear clean. Waiting until hands look dirty allows germs to pass to residents and surfaces. This option is tempting because dirt is easy to see, but visible dirt is not a reliable sign of contamination.

D) Only after removing a gown

Removing a gown is just one of many moments that call for hand hygiene. Hands need cleaning before and after resident contact, after body fluid contact, and between activities as well. This option may seem reasonable because gown removal is a clear event, but it covers only a small part of the standard practices.

Conclusion

Remember that hand hygiene follows standard infection-control practices, not a schedule or appearance. Clean hands between resident-care activities and after contact with body fluids to keep residents and yourself safe.

4. Which documentation entry is most objective?

A. Resident seemed very sick today

B. Resident was difficult and probably upset

C. Resident stated, "My stomach hurts," and reported pain as 7 out of 10

D. Resident was acting strangely

Answer: C. Resident stated, "My stomach hurts," and reported pain as 7 out of 10

Objective documentation records exactly what the resident said and measurable facts, as in the entry quoting the resident's complaint and the reported pain score of 7 out of 10.

Objective documentation sticks to facts you can observe or verify, such as direct quotes from the resident, numbers, and measurable details. Quoting the resident's own words and recording the pain rating gives other caregivers clear, reliable information that does not depend on your personal interpretation. This supports continuity of care and protects both the resident and the care team, because anyone reading the note knows exactly what was reported and when.

A) "Resident seemed very sick today"

Words like "seemed" and "very sick" describe your impression rather than observable facts, so another caregiver cannot tell what you actually saw. It may feel natural to summarize how a resident looks, but vague impressions belong in your verbal report, not as the main content of a chart entry.

B) "Resident was difficult and probably upset"

This entry mixes judgment ("difficult") with a guess about the resident's feelings ("probably upset"). Labeling behavior can bias the next caregiver and does not describe what happened. It is tempting to explain behavior, but documentation should describe actions and statements, not assign motives.

D) "Resident was acting strangely"

"Acting strangely" is subjective and means different things to different people. A reader cannot tell what the resident did or said. It may seem like a quick way to flag a concern, but specific descriptions of behavior and direct quotes are what make a note useful.

Conclusion

For documentation questions, look for entries with direct quotes, numbers, and observable facts. Avoid words that judge, guess, or summarize feelings, since those turn a factual note into a subjective opinion.

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5. A CNA is assisting one resident with dressing when another resident begins calling for help from the bathroom. The CNA hears the second resident say, "I am falling." What should the CNA do?

A. Ignore the call until dressing is complete

B. Respond immediately and obtain assistance while maintaining the first resident's safety

C. Tell the resident to wait because the CNA is busy

D. Leave both residents unattended

Answer: B. Respond immediately and obtain assistance while maintaining the first resident's safety

Respond immediately and obtain assistance while maintaining the first resident's safety.

A resident who says "I am falling" is at immediate risk of injury, so the CNA must act right away. The safest approach is to keep the first resident secure, such as guiding them to a safe seated position or staying within sight, and call for help from a coworker or use the call system so the second resident gets prompt assistance. This balances the duty to protect every resident with the reality that one CNA cannot safely manage two urgent situations alone. Getting help quickly prevents a fall and possible head injury, fracture, or hip fracture while still honoring the CNA's responsibility to the resident being dressed.

A) Ignore the call until dressing is complete

Finishing the dressing task first may feel efficient, but delaying a response to a resident who is actively falling risks serious injury. Falls can happen in seconds, and the CNA's scope of practice prioritizes immediate safety over completing routine care tasks.

C) Tell the resident to wait because the CNA is busy

This may seem like honest communication, but a resident who is already losing balance usually cannot wait safely. Telling them to wait does not address the immediate danger and could be seen as neglecting a resident in distress.

D) Leave both residents unattended

Abandoning the first resident to rush to the second creates a new safety risk, since the first resident may be unsteady, undressed, or unable to summon help. The goal is to secure one resident while summoning assistance for the other, not to leave anyone alone.

Conclusion

When a resident reports falling, act at once and bring in help rather than choosing between residents. Secure the resident in your care, call for assistance, and remember that prompt teamwork is the safest way to prevent injury.

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