CNA Exam Wisconsin Answers

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1. A CNA is providing perineal care to a female resident. Which action is required to prevent infection?

A. Wiping from back to front

B. Wiping from front to back

C. Using the same washcloth for the entire area

D. Rinsing only after completing all wiping

Answer: B. Wiping from front to back

Wiping from front to back is the required action to prevent infection during perineal care for a female resident.

In females, the urethra sits close to the vagina and anus, so bacteria from the rectal area can easily travel to the urinary tract and cause infection. Wiping from the front (urethra) toward the back (anus) moves germs away from the opening of the urinary system. This direction also keeps stool away from the vaginal area. Cleaning in this order with each stroke, using a clean part of the washcloth, lowers the risk of urinary tract and genital infections.

A) Wiping from back to front

This direction carries germs from the anal area toward the urethra and vagina, which raises the chance of infection. It may seem quicker or more natural to start at the back, but it works against the goal of keeping the urinary opening clean.

C) Using the same washcloth for the entire area

A single cloth reused across the whole perineal area spreads germs from one area to another. It may look like a time-saver, but it defeats the purpose of cleaning and can move bacteria toward the urethra.

D) Rinsing only after completing all wiping

Waiting until all wiping is done lets germs stay on the skin and be moved around during wiping. Rinsing as you go, and changing the cloth or washcloth surface, keeps the area cleaner and reduces infection risk.

Conclusion

Remember that perineal care for a female resident always moves from front to back, with clean cloth surfaces and rinsing as needed. This single habit protects the urinary tract and reflects safe, standard CNA practice.

2. A CNA notices a new reddened area on a residents heel. What should the CNA do?

A. Apply lotion and document that the area is red

B. Massage the reddened area vigorously

C. Report the finding to the licensed nurse and document the observation

D. Place a bandage over the area without reporting

Answer: C. Report the finding to the licensed nurse and document the observation

Report the new reddened area to the licensed nurse and document the observation.

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A new reddened area on a heel can be an early warning sign of pressure injury, so the CNA's role is to recognize it, keep the resident safe, and get the licensed nurse involved right away. Reporting the finding allows the nurse to assess the skin, determine the cause, and start appropriate interventions such as repositioning schedules or pressure-relieving devices. Documenting the observation creates a clear record so the care team can track changes over time. The CNA should also avoid putting pressure on the area and follow facility policy for skin checks.

A) Apply lotion and document that the area is red

Lotion may feel soothing, but it does not address the underlying pressure that caused the redness and can sometimes soften or irritate already damaged skin. Documenting alone without telling the nurse leaves the resident without a proper assessment and timely intervention.

B) Massage the reddened area vigorously

Massaging reddened skin can cause further damage to tissue that is already stressed from pressure. This option may seem helpful because massage is sometimes used for comfort, but over a pressure area it can worsen injury.

D) Place a bandage over the area without reporting

Covering the area hides a sign that the nurse needs to see and delays proper evaluation. A bandage alone does not relieve pressure or treat the cause, and failing to report goes against the CNA's responsibility to communicate changes in the resident's condition.

Conclusion

When you notice a new reddened area, treat it as a possible pressure injury: report it to the licensed nurse and document what you saw. Early reporting and clear documentation protect the resident and support the care team in preventing further skin breakdown.

3. In Wisconsin, CNAs generally work under the direct supervision of which licensed professionals?

A. An RN or LPN

B. A physician or pharmacist

C. A physical therapist or dietitian

D. A medical assistant or paramedic

Answer: A. An RN or LPN

In Wisconsin, CNAs generally work under the direct supervision of an RN or LPN.

Nurse aides provide hands-on basic care, and that care is directed and overseen by licensed nurses. The RN or LPN assesses the resident, develops the care plan, delegates tasks that fit the CNA's training, and remains accountable for the nursing care delivered. Working under a licensed nurse keeps the CNA within a clear chain of supervision and protects both the resident and the aide. This is why the correct answer is the RN or LPN.

B) A physician or pharmacist

Physicians and pharmacists hold licenses, but they do not provide the day-to-day nursing supervision of CNAs. A physician may write orders and a pharmacist may dispense medications, yet neither typically directs the aide's routine care tasks. This option can seem plausible because both are highly trained health professionals, but their roles are not the direct supervisory line for nursing assistants.

C) A physical therapist or dietitian

These specialists may give instructions within their own areas, such as mobility exercises or dietary needs, but they are not the licensed nurses who supervise CNA care overall. It is easy to assume any licensed clinician can supervise an aide, but the standard supervisory relationship for CNAs is with nursing staff.

D) A medical assistant or paramedic

Medical assistants and paramedics have valuable skills, but they are not RNs or LPNs and do not hold the nursing supervisory role over CNAs in this setting. This option may tempt test-takers because these workers also provide direct patient care, but their credentials and scope differ

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from licensed nursing supervision.

Conclusion

Remember that CNAs answer to licensed nurses, the RN or LPN, who direct and oversee their care. When a question asks about supervision, look for the licensed nursing role rather than other health professionals.

4. Which activity is an example of an activity of daily living that a CNA may assist a resident with?

A. Bathing

B. Diagnosing an infection

C. Changing a medication order

D. Interpreting an ECG

Answer: A. Bathing

Bathing is a basic activity of daily living that a CNA commonly assists residents with.

Activities of daily living (ADLs) are the everyday self-care tasks a person performs to function day to day, such as bathing, dressing, grooming, eating, toileting, and moving around. CNAs are trained and permitted to help residents with these personal care tasks, and bathing is one of the most common examples. Assisting with bathing supports hygiene, comfort, skin health, and dignity while keeping the resident as independent as possible. This falls squarely within the CNA scope of practice under the direction of the care team.

B) Diagnosing an infection

Diagnosing a medical condition requires the assessment and clinical judgment of a licensed provider such as a physician or nurse practitioner. It may seem tempting because CNAs do observe and report changes like redness, warmth, or unusual drainage, but noticing and reporting a concern is very different from making a diagnosis. The CNA's role is to report findings, not to determine the cause.

C) Changing a medication order

Medication orders are written and adjusted only by authorized prescribers, and following them is carefully controlled. This option may look appealing because CNAs sometimes remind residents about medications or observe them taking them, but altering an order is far outside the aide's role. CNAs must never change, adjust, or interpret medication instructions.

D) Interpreting an ECG

Reading and interpreting an electrocardiogram requires specialized clinical training and is the responsibility of providers such as physicians or specially trained nurses. It may seem plausible because CNAs can be involved in preparing a resident or attaching monitoring leads, but interpreting the tracing itself is not a nursing assistant task. Assisting with the setup is not the same as interpreting the results.

Conclusion

Remember that ADLs are everyday self-care tasks like bathing, dressing, and eating, and helping with them is a core CNA responsibility. Tasks involving diagnosis, medication orders, or interpreting test results belong to licensed providers and fall outside the nursing assistant's scope of practice.

5. When should a CNA perform hand hygiene during resident care?

A. Before and after resident care and whenever otherwise indicated

B. Only at the beginning of the shift

C. Only when hands appear visibly dirty

D. Only after removing gloves at the end of the shift

Answer: A. Before and after resident care and whenever otherwise indicated

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Hand hygiene should be performed before and after resident care and whenever otherwise indicated.

Germs can be picked up from a resident, from surfaces, or from the CNA's own skin and then carried to the next resident or to the CNA's face and food. Cleaning hands before care protects the resident from organisms the CNA may be carrying, and cleaning hands after care protects the CNA and the next resident from organisms just contacted. Hand hygiene is also needed at other moments, such as after touching blood, body fluids, or contaminated items, after using the restroom, before eating, and after removing gloves, because gloves can have tiny defects and hands can become contaminated while removing them. This is why the standard is to clean hands before and after each resident contact and at any other indicated time, not just at set points in the shift.

B) Only at the beginning of the shift

Hands become contaminated many times during a shift, so cleaning only once at the start leaves germs in place for every resident contact that follows. This option may seem appealing because it sounds like a simple routine, but it does not match how often contamination occurs.

C) Only when hands appear visibly dirty

Many germs are invisible, so hands can carry infection even when they look clean. Waiting for visible dirt misses the times when hand hygiene matters most, such as between residents or after touching body fluids.

D) Only after removing gloves at the end of the shift

Gloves do not replace hand hygiene, and hands can become contaminated during glove removal or through small defects in the gloves. Cleaning only at the end of the shift leaves residents unprotected during the entire shift and ignores the need to clean hands before care and between residents.

Conclusion

Remember that hand hygiene is tied to each resident contact and to any moment contamination may occur, not to a single time of day or to how hands look. Choosing the option that includes before and after care plus other indicated times reflects safe, standard CNA practice.

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