CNA Practice Test GA

CNA TestBank · Prepared Nov 29, 2026 · Ref RBWC9PJJ

Free preview: **5 of 50** questions. Create a free account at https://www.cnatestbank.com/register for 10 questions, or subscribe at https://www.cnatestbank.com/pricing for all 50.
For personal study only. Do not share or redistribute. Educational use only; not a substitute for accredited CNA training.

1. A resident begins coughing repeatedly while eating. What should the CNA do first?

A. Stop feeding and report the change

B. Offer larger bites to finish the meal

C. Give the resident water immediately

D. Continue feeding and document the cough later

Answer: A. Stop feeding and report the change

Stop feeding and report the change, since coughing during a meal can signal a swallowing problem that needs immediate attention.

Coughing while eating often means food or liquid is heading toward the airway instead of the stomach. The safest first step is to pause feeding right away so no more food enters the mouth while the resident is coughing. Stay with the resident, keep them upright, and let the coughing clear the airway. Then tell the charge nurse or supervisor promptly so the swallowing concern can be evaluated and the resident's diet or feeding approach can be adjusted. Reporting is part of the CNA's role of observing and communicating changes; the nurse decides on further assessment and care.

B) Offer larger bites to finish the meal

Larger bites increase the amount of food in the mouth and make choking more likely, especially when someone is already coughing. Finishing the meal quickly may seem efficient, but speed and bite size are never more important than airway safety.

C) Give the resident water immediately

Offering a drink while someone is actively coughing can push more material toward the airway and worsen the situation. It is natural to want to help by offering water, but the priority is to stop intake and let the resident clear the cough first.

D) Continue feeding and document the cough later

Continuing to feed ignores a warning sign and raises the risk of aspiration. Documenting is important, but it comes after acting to protect the resident; waiting until later misses the chance to prevent harm.

Conclusion

When a resident coughs during eating, stop feeding first, keep the resident safe and upright, and report the change right away. Recognizing and reporting swallowing warning signs is a core CNA responsibility.

2. A resident who normally has regular bowel movements has not had one for several days and reports abdominal discomfort. What should the CNA do?

A. Report the change to the nurse

B. Give a laxative without an order

C. Diagnose constipation

D. Tell the resident to wait another week

cnatestbank.com
Guest download · Ref RBWC9PJJ

Answer: A. Report the change to the nurse

Report the change to the nurse so the care team can assess the resident and decide on appropriate treatment.

A change from a resident's normal bowel pattern, especially when paired with abdominal discomfort, is important information that belongs with the nurse. The CNA's role is to observe, document, and report changes rather than to treat them. The nurse can assess the resident, check for possible causes such as medications, fluid intake, or activity level, and determine whether any intervention or further evaluation is needed. Prompt reporting helps prevent complications and keeps the resident safe.

B) Give a laxative without an order

Giving any medication without a prescriber's order falls outside the CNA's scope of practice and could cause harm, such as cramping, diarrhea, or electrolyte problems. It may seem like a quick way to relieve the resident's discomfort, but medication decisions must go through the nurse and prescriber.

C) Diagnose constipation

Making a diagnosis is a clinical judgment reserved for licensed providers. A CNA can recognize and report signs such as missed bowel movements and abdominal discomfort, but labeling the condition could lead to assumptions and delay proper evaluation.

D) Tell the resident to wait another week

Advising a resident to wait a week ignores a real change and the discomfort being reported, which could allow a problem to worsen. This response also steps beyond the CNA's role by giving clinical advice instead of passing the information to the nurse.

Conclusion

When a resident's normal pattern changes and they report discomfort, the safest and most appropriate action is to report it to the nurse promptly. Observing and communicating changes is a core CNA responsibility, while diagnosing and treating belong to licensed providers.

3. Which action helps prevent pressure injuries in a resident with limited mobility?

A. Reposition the resident according to the care plan

B. Massage reddened skin vigorously

C. Keep the resident in one position

D. Apply powder to every area of the skin

Answer: A. Reposition the resident according to the care plan

Repositioning the resident according to the care plan is the key action that helps prevent pressure injuries in a resident with limited mobility.

Pressure injuries form when constant pressure on one area cuts off blood flow to the skin and underlying tissue. Turning and repositioning the resident on the schedule set by the care plan shifts that pressure to new areas and lets the skin recover. This is a core part of CNA skin care for anyone who cannot move well on their own, and it should be done gently and documented as required.

B) Massaging reddened skin vigorously

Reddened skin is already showing signs of pressure damage, and rubbing it hard can injure fragile tissue and small blood vessels further. It may seem helpful because massage is often soothing, but over a pressure area it can make things worse. Report redness to the nurse instead of rubbing it.

C) Keeping the resident in one position

Staying in one position is exactly what allows pressure injuries to develop, since the same spots keep bearing weight and losing blood flow. It may seem easier or less disruptive for a resident with limited mobility, but prolonged pressure is the main cause of these wounds.

cnatestbank.com
Guest download · Ref RBWC9PJJ

D) Applying powder to every area of the skin

Powder can clump and hold moisture in skin folds, which softens and breaks down the skin and raises the risk of irritation and infection. It may seem like a way to keep skin dry, but it does not relieve pressure, which is the real cause of pressure injuries.

Conclusion

For test-takers, remember that relieving pressure through regular repositioning is the foundation of pressure injury prevention. Avoid rubbing reddened areas, avoid leaving residents in one position, and be cautious with powders, reporting any skin changes to the nurse.

4. A resident with hearing impairment does not respond to the CNA's question. What is the best approach?

A. Face the resident, speak clearly, and verify understanding

B. Shout from the doorway

C. Speak rapidly to finish the conversation

D. Ask the roommate to answer

Answer: A. Face the resident, speak clearly, and verify understanding

Face the resident, speak clearly, and verify understanding is the best approach when a resident with hearing impairment does not respond.

Hearing loss makes it harder to catch words, especially when the speaker is far away or not visible. Facing the resident lets them see your lips and facial expressions, which supports understanding. Speaking clearly at a normal, slightly slower pace and then checking that the message was received keeps communication respectful and effective. Verifying understanding, such as asking the resident to repeat back or confirm, ensures the resident truly heard and understood rather than simply nodding. This approach respects dignity and follows standard CNA communication practice.

B) Shout from the doorway

Shouting from a distance makes speech louder but not clearer, and it can distort sounds and feel disrespectful. Being far away also removes visual cues like lip reading. This option is tempting because raising volume seems like a quick fix, but distance and shouting usually make communication harder for someone with hearing impairment.

C) Speak rapidly to finish the conversation

Speaking quickly gives the resident less time to process words and read lips, which increases confusion and missed information. It may seem efficient, but rushing undermines understanding and can make the resident feel dismissed. Clear, unhurried speech is far more effective.

D) Ask the roommate to answer

Having the roommate respond takes communication away from the resident and can violate privacy and autonomy. It may seem helpful in the moment, but it does not address the resident's needs and can leave the resident feeling excluded from their own care. Always communicate directly with the resident first.

Conclusion

For residents with hearing impairment, face them, speak clearly, and confirm understanding. Avoid shouting, rushing, or speaking through others, since these reduce clarity and respect.

cnatestbank.com
Guest download · Ref RBWC9PJJ

5. A CNA who is not a certified medication aide is asked to independently administer a medication. What should the CNA do?

A. Explain that the task is outside the CNA's authorized role and notify the nurse

B. Administer it because the nurse is busy

C. Ask another CNA to administer it

D. Hide the medication until the nurse returns

Answer: A. Explain that the task is outside the CNA's authorized role and notify the nurse

Decline the task by explaining that medication administration is outside the CNA's authorized role and notify the nurse.

Medication administration is a nursing responsibility that requires specific training, verification, and legal authorization. A CNA who is not a certified medication aide does not have the education or legal scope to give medications independently, even when the nurse is busy. Accepting the task could cause serious harm to the resident through wrong drug, wrong dose, or wrong route errors, and it exposes the CNA to legal and disciplinary consequences. The safe, professional response is to politely explain the limit of the role and immediately inform the nurse so the resident receives the medication on time from someone authorized to give it.

B) Administer it because the nurse is busy

A staffing shortage or a busy nurse does not expand a CNA's legal scope of practice. This option is tempting because helping out feels like teamwork, but giving a medication without authorization puts the resident at risk and can lead to disciplinary action against the aide.

C) Ask another CNA to administer it

Passing the task to a coworker does not make it legal or safe. If the other CNA is also not a certified medication aide, that person has the same scope limits, and the resident still receives medication from an unqualified person.

D) Hide the medication until the nurse returns

Concealing medication delays the resident's treatment and could cause harm if a dose is time-sensitive. It also interferes with the nurse's ability to account for and safely store the drug, which is a medication security concern.

Conclusion

Know your scope of practice and speak up when a request falls outside it. Declining politely and notifying the nurse protects the resident, keeps you within the law, and demonstrates professional accountability.

cnatestbank.com
Guest download · Ref RBWC9PJJ