CNA Texas Exam Questions

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1. A nurse aide is assigned to feed a resident who has a history of dysphagia. Which action is most appropriate?

A. Offer liquids with a straw to make swallowing easier

B. Feed the resident quickly to finish before the tray gets cold

C. Place food on the unaffected side of the residents mouth

D. Give the resident a full spoonful of food at a time

Answer: C. Place food on the unaffected side of the residents mouth

Placing food on the unaffected side of the mouth helps the resident with dysphagia swallow more safely.

Dysphagia means swallowing is difficult or unsafe, and food or liquid can slip into the airway instead of the stomach. The side of the mouth that still has normal movement and sensation helps the resident chew and move food toward the throat with better control. By placing food on the unaffected side, the aide gives the resident the best chance to form a safe bolus and swallow without choking or aspirating. This is a simple feeding technique that stays within the CNA's scope and supports the care plan.

A) Offering liquids with a straw

Straws push liquid quickly to the back of the throat, which can overwhelm a person with dysphagia and raise the risk of aspiration. It may seem like a straw would make drinking easier, but faster flow is usually harder to control, not safer.

B) Feeding the resident quickly

Rushing a meal does not give the resident time to chew and swallow each bite completely, which increases choking risk. Finishing before the tray cools may feel practical, but safety and adequate swallowing time matter far more than speed.

D) Giving a full spoonful at a time

A large amount of food in the mouth is hard to manage when swallowing is impaired and can lead to pocketing or aspiration. A full spoon may look efficient, but smaller amounts are easier to control and swallow safely.

Conclusion

For a resident with dysphagia, slow, careful feeding with food placed on the stronger side of the mouth supports safe swallowing. Remember to avoid straws, large bites, and rushing, and always follow the resident's individualized care plan.

2. A nurse aide has several tasks to complete. Which resident should the CNA check on first?

A. A resident who needs their bed linens changed

B. A resident who is calling out that they are in pain

C. A resident who needs to be weighed before breakfast

D. A resident who wants help brushing their hair

Answer: B. A resident who is calling out that they are in pain

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The CNA should check first on the resident who is calling out that they are in pain, since pain is an urgent need that takes priority over routine tasks.

When several tasks are waiting, a CNA must sort them by urgency. A resident reporting pain may be experiencing a new or worsening problem, injury, or other serious condition, so this resident needs immediate assessment and reporting to the nurse. Routine care tasks can safely wait a few minutes, but unrelieved or sudden pain should never be delayed. Checking on the resident in pain first also allows the CNA to stay within scope by gathering information, offering comfort measures as allowed, and notifying the nurse promptly.

A) Bed linen change

Changing linens is important for comfort and skin health, but it is a scheduled, non-urgent task that can wait while more pressing needs are addressed. It may seem like a quick job to finish first, yet delaying a response to pain puts the resident at risk.

C) Weighing before breakfast

Weights are usually part of a morning routine and timing matters for accuracy, but a weigh-in is not an emergency. It may feel efficient to weigh the resident before the breakfast tray arrives, yet a resident in pain should be seen before any routine measurement.

D) Hair brushing

Helping with grooming supports dignity and independence, but it is a comfort task with no time pressure. It may seem kind to help this resident right away, but grooming can wait until urgent needs are met.

Conclusion

Always rank tasks by urgency: respond to pain, breathing problems, falls, or other signs of distress before routine care. When in doubt, check the resident who may be in danger or discomfort and report findings to the nurse.

3. A nurse aide is caring for a resident with an active infection that requires contact precautions. Which personal protective equipment should the aide don before entering the room?

A. Gloves only

B. Gown and gloves

C. Mask and eye protection

D. No PPE is required if the door remains closed

Answer: B. Gown and gloves

For contact precautions, the aide should put on a gown and gloves before entering the resident's room.

Contact precautions are used when germs can be spread by touching the resident or contaminated surfaces and objects in the room. A gown protects the aide's clothing and skin from contact with the resident, body fluids, and contaminated items, while gloves protect the hands. Both are put on before entering the room and removed carefully before leaving, followed by hand hygiene. This two-part barrier is the standard expectation for contact precautions and matches the aide's scope of practice for basic infection control.

A) Gloves only

Gloves protect the hands, but they leave clothing and forearms exposed to contact with the resident or contaminated surfaces. This option may seem appealing because gloves are the most familiar piece of PPE, but contact precautions call for a gown as well to prevent germs from being carried out of the room on clothing.

C) Mask and eye protection

Masks and eye protection guard against splashes and sprays and are used for droplet or airborne precautions or when splash risk exists. They do not address the main route of spread in contact precautions, which is direct and indirect touch. This option can be tempting because it sounds like thorough protection, but it does not match the precaution type described.

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D) No PPE is required if the door remains closed

Keeping the door closed does not stop germs from spreading through touch. The aide still touches the resident, linens, and surfaces while providing care, so barriers are needed. This option may seem logical if the aide thinks a closed door contains the infection, but contact precautions require PPE regardless of the door.

Conclusion

Remember that contact precautions focus on preventing spread through touch, so a gown and gloves are the required PPE before entering the room. Review the precaution categories and their matching PPE so you can choose the right barrier quickly on exam day.

4. A nurse aide is recording care provided to a resident. Which documentation entry is appropriate?

A. Resident seemed unhappy today

B. Resident ate 50% of lunch at 12:30 PM

C. Resident probably has a fever

D. Resident was being difficult during bath

Answer: B. Resident ate 50% of lunch at 12:30 PM

Recording that the resident ate 50% of lunch at 12:30 PM is appropriate because it states an objective, measurable fact with a specific time.

Good documentation in a resident's record describes what was actually observed and done, using facts, measurements, and times rather than opinions or guesses. "Ate 50% of lunch at 12:30 PM" is clear, specific, and can be verified, which helps the whole care team understand the resident's intake and spot changes in appetite. Nurse aides should record what they see and do, not personal judgments or medical conclusions, which belong to the nurse.

A) Resident seemed unhappy today

This entry describes a vague impression without specifics. Words like "seemed" and "unhappy" are subjective and do not tell the team when, how, or what was observed, so they cannot be acted on reliably. It may feel caring to note a resident's mood, but the record needs concrete observations instead.

C) Resident probably has a fever

Guessing at a medical diagnosis goes beyond the nurse aide's role. If a fever is suspected, the aide should report it to the nurse and document the actual measurement, such as a temperature reading, rather than a conclusion. It is tempting because the aide may truly believe the resident is ill, but the record must reflect facts, not diagnoses.

D) Resident was being difficult during bath

This wording is judgmental and labels the resident rather than describing behavior. It offers no useful information about what happened or what care was given. The aide may have felt frustrated, but documentation should stay neutral and factual, such as noting specific behaviors or refusals.

Conclusion

For CNA exams and real practice, choose documentation that is objective, specific, and timed. Record what you observe and do, report concerns to the nurse, and avoid opinions, guesses, and labels.

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5. A nurse aide measures a resident's radial pulse and counts 110 beats per minute. What should the aide do?

A. Record the pulse as normal and continue care

B. Record the pulse and report it to the licensed nurse

C. Recheck the pulse in one hour before reporting

D. Tell the resident their pulse is too fast

Answer: B. Record the pulse and report it to the licensed nurse

A radial pulse of 110 beats per minute should be recorded and reported to the licensed nurse.

A normal adult resting pulse is generally between 60 and 100 beats per minute, so 110 is above the usual range and needs attention. The nurse aide's job is to measure accurately, document the finding, and let the licensed nurse know promptly so the nurse can assess the resident and decide on any further action. Reporting an abnormal value is a routine part of the aide's scope of practice and helps keep the resident safe.

A) Record as normal and continue care

A value of 110 is above the typical resting range, so treating it as normal could delay needed follow-up. This option may seem appealing because the resident might look comfortable, but a fast pulse can be an early sign of a problem even when the person feels fine.

C) Recheck in one hour before reporting

Waiting an hour before telling anyone can postpone care if something is wrong. Rechecking can be useful when the nurse asks for it, but the aide should not decide on their own to hold back an abnormal finding.

D) Tell the resident their pulse is too fast

Explaining test results or giving a medical interpretation is outside the aide's role and can alarm the resident. The aide should share the measurement with the licensed nurse, who is responsible for interpreting it and talking with the resident.

Conclusion

Measure carefully, write down the exact number, and report abnormal vital signs to the licensed nurse right away. Knowing the normal ranges and staying within your role keeps residents safe and keeps you practicing correctly.

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