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CNA TestBank · Prepared Nov 28, 2026 · Ref 3TBBYTEC

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1. A resident with dementia repeatedly asks when lunch will be served. What is the best response?

A. Answer calmly and provide simple reassurance

B. Tell the resident to stop asking

C. Argue that the resident was already told

D. Ignore the resident

Answer: A. Answer calmly and provide simple reassurance

Answer calmly and provide simple reassurance is the best response because it respects the resident's feelings and reduces distress.

Dementia affects memory and the ability to reason, so the resident truly does not remember the earlier answer. Repeating the question is a way of expressing uncertainty or anxiety. A calm, simple reply such as "Lunch is at noon, and I'll help you get ready" gives reassurance without correction or confrontation. This approach supports dignity, lowers agitation, and keeps the interaction positive, which is within the CNA's scope of practice.

B) Tell the resident to stop asking

This response dismisses the resident's concern and can increase confusion, anxiety, or agitation. It may seem like a quick way to end the repeated questioning, but it does not address the underlying memory loss and can damage trust.

C) Argue that the resident was already told

Arguing relies on the resident's memory working correctly, which it cannot do with dementia. It may feel logical to point out that the answer was already given, but it often leads to frustration and conflict rather than calm.

D) Ignore the resident

Ignoring the resident leaves them feeling unheard and may raise their anxiety or agitation. It might seem like a way to avoid reinforcing the question, but silence does not meet the resident's need for reassurance and can harm the care relationship.

Conclusion

With dementia, repeated questions come from memory loss and anxiety, not from stubbornness. Calm, simple reassurance is the safest and most supportive response, while correcting, arguing, or ignoring the resident can increase distress.

2. A resident asks to speak privately with a family member. What should the CNA do?

A. Provide reasonable privacy for the communication

B. Tell the family member everything discussed

C. Require another staff member to remain during the conversation

D. Tell the resident private communication is not permitted

Answer: A. Provide reasonable privacy for the communication

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Providing reasonable privacy for the resident's conversation respects the resident's right to communicate privately with family.

Resident rights include the freedom to communicate privately with family members and others. When a resident asks to speak privately, the CNA should support that request by giving reasonable privacy, such as stepping away or helping the resident to a private area, while still keeping the resident safe and within the CNA's scope of practice. This honors the resident's dignity and autonomy.

B) Tell the family member everything discussed

Sharing the details of a private conversation with others would violate the resident's confidentiality and trust. This option may seem helpful if the CNA thinks the family needs information, but the resident decides who hears the conversation.

C) Require another staff member to remain during the conversation

Stationing another staff member in the room would undercut the privacy the resident asked for. A CNA might choose this out of concern for safety or supervision, but routine monitoring of a private family conversation is not appropriate unless there is a specific safety concern.

D) Tell the resident private communication is not permitted

Refusing a private conversation restricts a right the resident is entitled to. This option may seem like a way to stay in control of the unit, but limiting communication without a valid reason goes against resident rights.

Conclusion

Remember that residents have the right to private communication with family. Support reasonable privacy while maintaining safety, and never share or restrict what the resident chooses to discuss.

3. A resident's call light is out of reach. What should the CNA do?

A. Place the call light within the resident's reach

B. Tell the resident to call out if help is needed

C. Leave it because the resident may reach it

D. Place it on the floor

Answer: A. Place the call light within the resident's reach

Placing the call light within the resident's reach keeps the resident safe and able to summon help when needed.

A call light is a resident's lifeline for asking for help, so it must always be positioned where the resident can comfortably and reliably reach it, even while lying in bed or sitting in a chair. Keeping the call light accessible prevents the resident from attempting unsafe movements, such as leaning, stretching, or climbing out of bed, which can lead to falls and injury. This simple action supports independence and dignity while meeting a basic safety and supervision responsibility within the CNA scope of practice.

B) Tell the resident to call out for help

Relying on shouting assumes the resident can project their voice and that staff will hear it, which is not dependable in a busy facility. Residents who are weak, short of breath, or have speech difficulties may not be able to call out at all. This option may seem friendly and reassuring, but it leaves the resident without a reliable way to get help.

C) Leave it because the resident may reach it

Assuming the resident can reach the call light ignores differences in strength, mobility, and positioning that change from moment to moment. A device that is out of reach now may stay out of reach, and the resident may try to stretch for it and fall. This choice may feel like avoiding unnecessary fuss, but it leaves a known hazard unaddressed.

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D) Place it on the floor

The floor is not a safe or reachable location for a call light, especially for a resident in bed or with limited mobility. Bending or reaching down toward the floor increases fall risk, and the device could be kicked, soiled, or damaged. This option might seem like a quick fix, but it creates new safety problems rather than solving the original one.

Conclusion

Always make sure the call light is within the resident's reach before leaving the bedside, and reposition it whenever the resident's position changes. This small habit is a core part of fall prevention and resident safety on the CNA exam and in daily care.

4. After completing care involving body fluids, what should the CNA do with contaminated gloves?

A. Remove them promptly and perform hand hygiene

B. Keep them on until the end of the shift

C. Wear them into the next resident's room

D. Wipe them with a towel and continue using them

Answer: A. Remove them promptly and perform hand hygiene

After completing care involving body fluids, the CNA should remove contaminated gloves promptly and perform hand hygiene.

Gloves are single-use personal protective equipment that protect the CNA and the resident during a task, but they are not a substitute for clean hands. Once care involving body fluids is finished, the gloves have done their job and should come off right away using proper technique so bare hands never touch the contaminated outer surface. Hand hygiene immediately afterward removes any germs that may have reached the skin during removal and breaks the chain of transmission before the CNA moves on to any other task or resident. This sequence protects the CNA, the resident just cared for, and everyone else in the facility.

B) Keep them on until the end of the shift

Wearing the same gloves for hours feels efficient, but the gloves become a vehicle for spreading germs to every surface and person touched. Prolonged wear also causes moisture buildup and skin breakdown, and it tempts the CNA to skip hand hygiene. Gloves are meant for a single task, not a whole shift.

C) Wear them into the next resident's room

Carrying gloves from one resident to another moves germs directly between people, which is exactly what infection control aims to prevent. It may seem like a time-saver during a busy shift, but each resident deserves clean hands and fresh gloves. Hand hygiene and a new pair of gloves belong between residents.

D) Wipe them with a towel and continue using them

Wiping gloves with a towel does not clean or disinfect them; it simply smears contamination around and may transfer germs to the towel and the CNA's hands. Gloves cannot be washed, disinfected, or reused. This option may appeal as a way to save supplies, but it leaves the CNA's hands contaminated and puts the next resident at risk.

Conclusion

Remember that gloves are task-specific and disposable: remove them as soon as the task is done, then perform hand hygiene before touching anything else. Choosing prompt removal plus hand hygiene is the safest, most reliable habit for every CNA.

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5. A resident reports new mouth pain that makes chewing difficult. What should the CNA do?

A. Report the complaint to the nurse

B. Give the resident pain medication

C. Tell the resident to stop eating

D. Change the resident's diet independently

Answer: A. Report the complaint to the nurse

New mouth pain that makes chewing difficult should be reported to the nurse promptly.

The CNA is the caregiver who spends the most time with the resident and is often the first to notice a change. New pain is a change in condition, and mouth pain can point to problems such as sores, infection, broken teeth, or poorly fitting dentures. Reporting what the resident said, when it started, and how it affects eating gives the nurse the information needed to assess the resident and decide on treatment. The CNA's role is to observe, document, and communicate, not to diagnose or treat.

B) Give the resident pain medication

Giving medication is outside the CNA's scope of practice. Even when a resident already has an order for pain relief, the CNA does not decide when to give it or hand it out. This option may seem caring and quick, but acting beyond your training can cause harm and breaks facility policy.

C) Tell the resident to stop eating

Advising a resident to stop eating is not the CNA's decision and could lead to poor nutrition and hydration. It may seem like a simple way to prevent pain, but skipping meals is not a safe solution. The nurse needs to know about the pain so the cause can be addressed while the resident's intake is monitored.

D) Change the resident's diet independently

Diet orders are set by the care team, often with input from a dietitian and the resident's provider. A CNA cannot change a diet on their own, even to softer foods. This option may seem helpful, but altering the diet without an order can create choking risks or nutritional problems and hides the real issue from the nurse.

Conclusion

When a resident reports a new symptom, the safest action is to report it to the nurse and document what you observed. Stay within your scope of practice, and let the nurse assess and decide on treatment.

6. A resident using a walker suddenly becomes unsteady while walking with the CNA. What should the CNA do?

A. Help the resident reach a safe position and obtain assistance as needed

B. Tell the resident to walk faster

C. Pull the walker away

D. Continue walking without stopping

Answer: A. Help the resident reach a safe position and obtain assistance as needed

Help the resident reach a safe position and obtain assistance as needed.

When a resident using a walker suddenly becomes unsteady, the CNA's first priority is to keep the resident from falling. The CNA should stay close, guide or ease the resident toward a nearby chair, bed, or wall so the resident has something stable to hold or sit on, and then call for help if extra hands are needed. This protects the resident from injury and stays within the CNA's scope of practice, since the CNA is not expected to catch or carry a falling person alone. After the resident is safe, the CNA should report the episode and any changes in the resident's steadiness to the nurse.

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B) Tell the resident to walk faster

Urging a resident to speed up when balance is already failing adds to the risk of a fall. Hurrying does not restore steadiness and can make the resident more frightened and less able to control their steps. It may seem like a way to get the resident to the destination quickly, but safety comes before speed.

C) Pull the walker away

Taking the walker removes the very support the resident is relying on and can cause an immediate fall. The walker is the resident's main source of stability, so pulling it away increases danger rather than reducing it. This option may attract someone who wants to clear an obstacle, but the device must stay with the resident.

D) Continue walking without stopping

Ignoring the unsteadiness lets a dangerous situation continue and gives the resident no chance to regain balance. The CNA needs to pause and secure the resident's safety right away. Continuing on may seem efficient, but it leaves the resident at high risk for a fall.

Conclusion

When a resident becomes unsteady, stop, steady the resident, and guide them to a safe position such as a chair or wall, then get help. Never hurry the resident, remove the walker, or keep walking as if nothing is happening. Report the event to the nurse afterward.

7. A resident who was previously continent suddenly begins having urinary incontinence. What should the CNA do?

A. Report the change to the nurse

B. Tell the resident it is normal aging

C. Restrict fluids without an order

D. Ignore the change unless it continues for a week

Answer: A. Report the change to the nurse

Report the change to the nurse promptly, since a sudden onset of urinary incontinence in a previously continent resident is a significant change that needs nursing assessment.

A new loss of bladder control is not something a CNA should treat as routine. Sudden incontinence can point to a urinary tract infection, medication side effects, constipation, mobility problems, or other medical issues that only the nurse can evaluate. The CNA's role is to observe, document what was seen, and communicate the change to the nurse right away so the resident can be assessed and a care plan can be updated. Reporting is a core part of the CNA's scope of practice and protects the resident's dignity and health.

B) Tell the resident it is normal aging

This response dismisses a real change and gives the resident inaccurate reassurance. Incontinence is not an unavoidable part of aging, and a sudden change deserves evaluation. It may feel kind to comfort the resident, but the CNA should not offer explanations that belong to the nurse or provider.

C) Restrict fluids without an order

Limiting fluids is a nursing or provider decision and can cause dehydration, confusion, and worsened health. Withholding fluids without an order is outside the CNA's scope. It may seem like a quick way to reduce accidents, but it does not address the cause and can harm the resident.

D) Ignore the change unless it continues for a week

Waiting a week delays care and allows a possible infection or other problem to worsen. A sudden change is exactly the kind of finding that should be reported immediately. It may seem reasonable to watch for a pattern, but the CNA should report now and continue observing afterward.

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Conclusion

When a resident's condition changes suddenly, the CNA's job is to observe, document, and report to the nurse without delay. Avoid making independent decisions about fluids, giving explanations about aging, or waiting to see if the problem resolves on its own.

8. A resident asks whether a newly prescribed medication will cure the resident's illness. What should the CNA do?

A. Refer the question to the nurse or another appropriate licensed professional

B. Guarantee that the medication will work

C. Tell the resident to stop taking it

D. Recommend a different medication

Answer: A. Refer the question to the nurse or another appropriate licensed professional

Refer the question to the nurse or another appropriate licensed professional.

CNAs are not licensed to explain medications, their purpose, or expected outcomes, so the safe and appropriate response is to direct the resident's question to the nurse or another licensed professional. This protects the resident from misinformation and keeps the CNA within the legal scope of practice. The CNA can still respond with empathy, acknowledge the resident's concern, and reassure the resident that the nurse will answer the question promptly.

B) Guarantee that the medication will work

Promising a cure goes beyond the CNA's role and could create false hope or legal risk if the medication does not produce the expected result. It may feel reassuring in the moment, but only the prescriber or nurse can speak to what a medication can or cannot do.

C) Tell the resident to stop taking it

Advising a resident to stop a prescribed medication can cause serious harm and interferes with the care plan set by the licensed team. This option may seem like a way to address the resident's doubts, but any change in medication must come from the prescriber.

D) Recommend a different medication

Suggesting another medication amounts to giving medical advice, which is outside the CNA's training and legal scope. Even a well-intentioned suggestion could conflict with the resident's prescriptions or allergies, so medication decisions belong to the licensed care team.

Conclusion

When residents ask about medications, cures, or treatment changes, the CNA's job is to listen supportively and route the question to the nurse or another licensed professional. Staying within scope protects both the resident and the CNA.

9. Under current Georgia nursing-home rules, which resident would not be appropriate for feeding and hydration assistance by a dining assistant?

A. A resident with difficulty swallowing

B. A resident who safely eats independently

C. A resident who needs help opening a food package

D. A resident who needs help positioning a napkin

Answer: A. A resident with difficulty swallowing

A resident with difficulty swallowing is not appropriate for feeding and hydration assistance by a dining assistant.

Dining assistants are trained to help residents with routine eating tasks, such as opening packages, setting up trays, and providing basic mealtime help. Swallowing problems, however, involve a risk of choking and aspiration, where food or liquid can enter the airway. That risk requires assessment and care by a licensed nurse or other qualified clinical staff, not a dining assistant. Georgia nursing-home rules reflect this

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safety line by limiting what dining assistants may do.

B) A resident who safely eats independently

This resident does not need feeding assistance at all, so the question of whether a dining assistant may help does not really apply. It can seem like a trick option, but the key point is that independent eating does not create the clinical risk that swallowing difficulty does.

C) A resident who needs help opening a food package

Opening a package is a routine mealtime task that dining assistants are trained to perform. It may seem clinical because it involves food, but it does not involve swallowing safety or any hands-on feeding risk.

D) A resident who needs help positioning a napkin

Placing or adjusting a napkin is a simple dining setup task well within the dining assistant role. It may sound like personal care that requires a nurse, but it carries no swallowing or aspiration risk.

Conclusion

Focus on safety risk when answering questions about dining assistants. Routine mealtime help is within their role, but any resident with swallowing difficulty needs clinical staff because of the danger of choking and aspiration.

10. Under Georgia nursing-home rules, who must directly supervise a dining assistant?

A. A registered nurse or licensed practical nurse

B. Another dining assistant

C. A family member

D. A housekeeping employee

Answer: A. A registered nurse or licensed practical nurse

A registered nurse or licensed practical nurse must directly supervise a dining assistant under Georgia nursing-home rules.

Dining assistants help residents during meals, but they are unlicensed workers performing a delegated task. State rules require that this task stay under the direct oversight of a licensed nurse, because the nurse is accountable for the resident's nutrition and safety. The nurse can assess swallowing problems, watch for choking or changes in intake, and step in when a resident needs clinical judgment. This keeps the dining assistant within a safe, supervised role and protects residents during one of the highest-risk times of the day.

B) Another dining assistant

A fellow dining assistant has no license and no authority to supervise or evaluate care. It may seem reasonable because a more experienced aide knows the routine, but peer experience does not meet the legal standard for direct supervision. Only a licensed nurse can carry that responsibility.

C) A family member

Family members may be present and helpful at meals, but they are not part of the facility's care team and cannot supervise staff. This option is tempting because families often know the resident's preferences best, yet supervision of a dining assistant must come from a licensed nurse on staff.

D) A housekeeping employee

Housekeeping staff work in the building but have no clinical training or authority over feeding assistance. It may look like any staff member nearby could watch the dining assistant, but supervision requires a licensed nurse who can recognize and respond to a resident's changing condition.

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Conclusion

Remember that unlicensed dining assistants always work under the direct supervision of a licensed nurse, such as an RN or LPN. When a question asks who supervises a delegated nutrition task, choose the licensed nurse.

11. What is the minimum training time specified in Georgia rules for a nursing-home dining assistant training program?

A. 16 hours

B. 4 hours

C. 8 hours

D. 24 hours

Answer: A. 16 hours

The minimum training time specified in Georgia rules for a nursing-home dining assistant program is 16 hours.

Georgia regulations set a required minimum of 16 hours of training for nursing-home dining assistants. This training prepares the assistant to safely support residents during meals, including understanding special diets, safe feeding techniques, and recognizing swallowing or choking risks. Knowing the specific number matters because dining assistants play a direct role in resident nutrition and safety, and the state sets a clear standard to ensure they are properly prepared before helping residents eat.

B) 4 hours

Four hours may seem like a reasonable short orientation, but it falls far short of the state minimum and would not provide enough time to cover diet types, feeding safety, and resident rights. It is a tempting choice because brief trainings are common in some settings, but Georgia requires more preparation for this role.

C) 8 hours

Eight hours sounds like a full workday and may feel sufficient, which makes it an appealing distractor. However, the Georgia rule sets the minimum higher than a single shift, so this amount does not meet the required standard.

D) 24 hours

Twenty-four hours may seem appropriate because more training often sounds safer, and some programs do offer extended training. Still, the state minimum is a specific figure, and overestimating it can lead to choosing the wrong answer on an exam.

Conclusion

Remember that Georgia requires at least 16 hours of training for nursing-home dining assistants. When a question asks for a state-specified minimum, focus on the exact regulatory number rather than what seems like a reasonable amount of training.

12. Which topic is included in Georgia nursing-home dining assistant training?

A. Recognizing changes in residents that are inconsistent with their normal behavior

B. Prescribing medications

C. Diagnosing swallowing disorders

D. Performing independent nursing assessments

Answer: A. Recognizing changes in residents that are inconsistent with their normal behavior

Georgia nursing-home dining assistant training includes recognizing changes in residents that are inconsistent with their normal behavior.

Dining assistants spend a lot of time with residents during meals, so they are in a good position to notice when something seems off, such as a resident who suddenly refuses food, seems more confused, or behaves differently than usual. Training teaches them to recognize these

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changes and report them to the nurse right away. This keeps the resident safe and supports the care team, and it stays within the assistant's role of observing and reporting rather than diagnosing or treating.

B) Prescribing medications

Prescribing medications requires a licensed provider such as a physician or nurse practitioner, so it falls far outside dining assistant training. This option may seem tempting because dining assistants do work with residents who take medications, but their role is limited to observing and reporting, not prescribing.

C) Diagnosing swallowing disorders

Diagnosing swallowing problems is a clinical task for speech-language pathologists and other licensed clinicians. Dining assistants may be trained to watch for signs of trouble with eating or swallowing and to report them, but making a diagnosis is beyond their scope and not part of their training.

D) Performing independent nursing assessments

Independent nursing assessments are performed by licensed nurses, not dining assistants. This option can seem plausible because dining assistants do observe residents closely, but their observations are reported to the nurse rather than turned into independent assessments.

Conclusion

Dining assistants are trained to observe residents during meals and report changes in behavior or eating to the nurse. Remember that their role centers on recognizing and reporting, while prescribing, diagnosing, and independent nursing assessments belong to licensed professionals.

13. Under Georgia nursing-home rules, what is the purpose of dining assistants in relation to required nursing staff?

A. They supplement rather than replace required nursing staff

B. They replace licensed nursing staff

C. They are counted as licensed nursing staff

D. They independently determine nursing staffing needs

Answer: A. They supplement rather than replace required nursing staff

Dining assistants supplement rather than replace the required nursing staff.

Georgia nursing-home rules allow dining assistants to help residents during meals, but their role is supportive only. They do not take the place of the nursing staff that regulations require to be present and providing care. Dining assistants can assist with meal setup, encourage eating, and help with tasks within their training, while licensed and required nursing staff remain responsible for resident care and supervision. This keeps residents safe and ensures the facility meets staffing requirements.

B) They replace licensed nursing staff

This option seems appealing because dining assistants do work alongside nursing staff at mealtime, so it can look like they take over some duties. However, dining assistants are not licensed nursing staff and cannot fill licensed nursing roles. Replacing required licensed staff with dining assistants would leave residents without the skilled care and oversight the rules require.

C) They are counted as licensed nursing staff

It is easy to assume that anyone helping at meals is part of the nursing team for staffing purposes. Dining assistants are not licensed nursing staff and are not counted toward licensed staffing requirements. Their role is to add mealtime support, not to satisfy licensure-based staffing numbers.

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D) They independently determine nursing staffing needs

This may seem plausible because dining assistants see residents at meals and might notice changes in appetite or eating ability. However, deciding nursing staffing needs is outside their scope. Staffing decisions belong to facility administration and nursing leadership, and dining assistants report observations rather than set staffing levels.

Conclusion

Remember that dining assistants are extra support at mealtime and do not replace, count as, or make decisions about required nursing staff. Knowing this boundary helps you answer staffing and scope-of-practice questions correctly.

14. A Georgia nursing-home dining assistant is asked to feed a resident with recurrent lung aspiration. What should the dining assistant do?

A. Do not provide the feeding assistance and notify the appropriate nurse

B. Proceed because the resident is hungry

C. Feed the resident only solid food

D. Change the resident's diet independently

Answer: A. Do not provide the feeding assistance and notify the appropriate nurse

A dining assistant should not feed a resident with recurrent lung aspiration and should notify the appropriate nurse.

Feeding a resident who has recurrent lung aspiration carries a high risk of food or liquid entering the airway, which can cause choking or serious lung infection. A dining assistant's role is limited to basic dining support for stable residents, and this resident's condition requires assessment and direction from licensed nursing staff. The safe and appropriate action is to stop, avoid providing the feeding, and report the situation to the nurse so the resident's needs and safety can be managed by someone with the proper training and authority.

B) Proceed because the resident is hungry

Hunger is understandable, but it does not remove the danger of aspiration. Acting on the resident's appetite without considering the clinical risk could lead to choking or aspiration pneumonia, so this choice puts the resident in harm's way.

C) Feed the resident only solid food

Changing the type of food does not make feeding safe for someone with recurrent aspiration, and deciding what texture or consistency is appropriate is outside a dining assistant's role. This option sounds helpful but still involves feeding a high-risk resident without nursing direction.

D) Change the resident's diet independently

Diet orders are determined by licensed providers and the care team, not by dining assistants. Altering a diet on your own could worsen the resident's condition and falls outside the scope of practice, even though it may seem like a quick way to reduce risk.

Conclusion

When a resident has a known swallowing or aspiration risk, the safest response is to stop and involve the nurse rather than improvise. Knowing the limits of your role protects both the resident and you.

15. A CNA wants to work as a certified medication aide. Which statement is correct?

A. The CNA must meet separate state requirements for certified medication aides

B. Every CNA automatically has medication-aide authority

C. A CNA can administer medications after one shift of orientation

D. A family member can authorize the CNA to administer medications

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Answer: A. The CNA must meet separate state requirements for certified medication aides

Certified medication aide status requires meeting separate state requirements beyond the CNA credential.

Each state sets its own rules for who may give medications in long-term care and other settings. A CNA certificate does not include medication administration, so a CNA who wants to work as a certified medication aide must complete the additional training, testing, and registration that the state requires. This keeps medication tasks within a defined scope of practice and protects residents from errors.

B) Automatic authority

Basic CNA training does not cover medication administration, so the CNA credential alone never carries medication-aide authority. This option may seem appealing because CNAs work closely with residents and may help with self-administration in some settings, but passing medications is a separate regulated task.

C) One shift of orientation

A single orientation shift cannot substitute for the formal medication-aide training and state approval process. It may sound practical because new staff often shadow experienced workers, but shadowing does not create legal authority to administer medications.

D) Family authorization

Families can be involved in care decisions, but they cannot grant a CNA permission to perform a task outside the CNA scope of practice. This option may seem reasonable because families often request help, yet authority to give medications comes from state law and facility policy, not from relatives.

Conclusion

Remember that scope of practice is set by the state, and moving into medication aide work means meeting those separate requirements first. When a question involves a task beyond basic CNA duties, look for the answer that points to additional training and official authorization.

16. A Georgia long-term-care resident wants to file a complaint concerning care. What should the CNA do?

A. Help the resident access the appropriate complaint or grievance process

B. Tell the resident complaints are not permitted

C. Discourage the resident from reporting the concern

D. Threaten to withhold care

Answer: A. Help the resident access the appropriate complaint or grievance process

Helping the resident access the appropriate complaint or grievance process respects the resident's right to voice concerns without fear.

Residents in long-term care have a legal right to file grievances and to be free from retaliation. When a resident says they want to complain, the CNA's role is to support that right by connecting them with the facility's grievance procedure, the ombudsman, or other appropriate channels. This keeps the resident informed and empowered while staying within the CNA's scope of practice, which is to facilitate access rather than to investigate or resolve the complaint personally.

B) Telling the resident complaints are not permitted

This directly denies a federally protected resident right and could be seen as intimidation. It may seem like a quick way to avoid conflict, but residents are always allowed to raise concerns.

C) Discouraging the resident from reporting the concern

Persuading a resident not to complain interferes with their right to self-advocate and can create a culture of silence. It might feel like a way to keep peace on the unit, but it undermines trust and dignity.

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D) Threatening to withhold care

This is retaliation and neglect, both serious violations of resident rights and facility policy. It may appear to stop the complaint in the moment, but it harms the resident and places the CNA at risk of discipline or legal consequences.

Conclusion

Supporting a resident's right to file a grievance is a core CNA responsibility. Never block, discourage, or punish a resident for speaking up, and instead guide them to the proper complaint process.

17. A resident asks for privacy during a conversation with a visitor. What should the CNA do when circumstances permit?

A. Provide reasonable privacy for the conversation

B. Require staff to listen to the conversation

C. Tell the resident all visitors must be monitored

D. Move the resident to a public hallway

Answer: A. Provide reasonable privacy for the conversation

When circumstances permit, the CNA should provide reasonable privacy for the resident's conversation with a visitor.

Resident rights include the right to privacy for visits and conversations, and CNAs support this by stepping back, closing a door or curtain when safe, and staying available without intruding. Privacy is balanced with safety and facility policy, which is why the question says "when circumstances permit." The goal is to respect the resident's dignity and personal choice while still keeping them safe and within the CNA's scope of practice.

B) Require staff to listen to the conversation

Having staff listen in on a private conversation invades the resident's privacy and can make the resident feel watched or disrespected. It may seem protective, but routine monitoring of conversations is not part of supporting resident rights.

C) Tell the resident all visitors must be monitored

This statement is not accurate and takes away the resident's sense of control over their own visits. A CNA should not make blanket rules about visitors; privacy and safety are handled according to facility policy and the resident's needs.

D) Move the resident to a public hallway

Moving a resident into a public area does the opposite of providing privacy and exposes the conversation to others. It might be chosen to keep the resident visible, but it ignores the resident's request for privacy and their dignity.

Conclusion

Respecting resident rights means honoring reasonable requests for privacy during visits whenever safety and circumstances allow. Choose the option that protects dignity and privacy without overstepping CNA scope.

18. A resident experiences a sudden adverse change in condition. Which action is appropriate for the CNA?

A. Report the change promptly and ensure the response is documented according to facility procedure

B. Wait until the next scheduled assessment

C. Change the resident's treatment plan

D. Diagnose the cause before reporting it

Answer: A. Report the change promptly and ensure the response is documented according to facility procedure

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Report the change promptly and make sure the response is documented according to facility procedure.

A sudden adverse change in a resident's condition is a signal that needs immediate attention. The CNA's role is to observe and recognize the change, notify the licensed nurse or charge nurse right away, and follow facility procedure for documenting what was seen and what was done. Quick reporting allows the care team to assess and respond before the resident's condition worsens. Documentation creates a clear record of the event and the actions taken, which supports continuity of care and protects both the resident and the staff member.

B) Wait until the next scheduled assessment

Delaying action until the next scheduled assessment can allow a serious problem to progress unchecked. Scheduled checks are not designed to catch sudden changes, and a resident's condition can decline quickly in the meantime. This option may seem calm or cautious, but prompt reporting is the safer and expected response.

C) Change the resident's treatment plan

Treatment plans are developed and revised by licensed professionals such as the nurse, physician, or care team. A CNA does not have the authority or training to alter a plan of care. This option may appeal to someone who wants to fix the problem directly, but the proper step is to report the change so the appropriate clinician can decide on any plan adjustments.

D) Diagnose the cause before reporting it

Diagnosing is outside the CNA scope of practice and requires clinical training and licensure. Waiting to figure out the cause delays the care the resident needs and risks harm. This option may seem thorough, but the CNA should report observations promptly and let the licensed nurse or provider determine the cause and treatment.

Conclusion

When a resident's condition changes suddenly, act quickly: report it to the licensed nurse and document according to facility policy. Recognizing your scope of practice and knowing when to escalate are core CNA skills that keep residents safe.

19. A resident has a prescribed therapeutic diet. The CNA notices that the meal delivered does not match the resident's care plan. What should the CNA do?

A. Hold the meal and notify the appropriate nurse or dietary staff according to facility procedure

B. Tell the resident to eat the meal anyway

C. Change the diet independently

D. Discard the meal without reporting the problem

Answer: A. Hold the meal and notify the appropriate nurse or dietary staff according to facility procedure

Hold the meal and notify the appropriate nurse or dietary staff according to facility procedure.

A therapeutic diet is ordered for a specific clinical reason, such as diabetes, heart disease, kidney disease, or food allergies. When the meal on the tray does not match the care plan, the safe response is to pause and report the discrepancy through the proper chain rather than act on your own. The nurse or dietary staff can verify the order, correct the tray, and make sure the resident gets the right food. This protects the resident from harm and keeps the CNA within their scope of practice.

B) Tell the resident to eat the meal anyway

Serving the wrong diet can cause real harm, such as blood sugar swings in a resident with diabetes, fluid overload in a resident on a fluid-restricted diet, or an allergic reaction. It may feel easier to avoid conflict or waste, but the resident's safety comes first, and the CNA should not encourage eating food that does not match the prescribed diet.

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C) Change the diet independently

Diet orders are clinical decisions made by the provider and carried out through the care plan, so a CNA does not have the authority to change them. It might seem helpful to swap items or adjust the tray, but doing so bypasses the nurse and dietitian and can lead to serious errors. The right step is to report the mismatch, not fix it alone.

D) Discard the meal without reporting the problem

Throwing the tray away hides the error and leaves the resident without a meal, and it also prevents staff from finding out why the wrong tray was delivered. It may feel like a quick way to remove the problem, but it creates a new one and does not correct the system issue. The meal should be held and the problem reported so it can be resolved properly.

Conclusion

When a meal does not match the prescribed therapeutic diet, hold the tray and report it to the nurse or dietary staff right away. Never serve, alter, or discard a therapeutic meal on your own; following facility procedure protects the resident and keeps you within CNA scope of practice.

20. Four residents request assistance at the same time. Which request should receive the highest priority?

A. A resident who reports sudden severe shortness of breath

B. A resident who wants help selecting clothes

C. A resident who requests a magazine

D. A resident who wants help arranging personal belongings

Answer: A. A resident who reports sudden severe shortness of breath

Sudden severe shortness of breath is a life-threatening emergency and must be addressed first.

When several residents need help at once, a nursing assistant must sort requests by urgency, not by the order they were made. Sudden severe shortness of breath can signal a serious problem such as a blood clot, heart failure, or an asthma attack, and the resident's condition can worsen within minutes. This resident needs immediate assessment and prompt notification of the nurse, so this request takes priority over routine comfort and activity needs. The other requests are important to the residents but can safely wait a short time while the emergency is handled.

B) Help selecting clothes

Choosing an outfit is a routine activity-of-daily-living task that supports dignity and independence, but it carries no risk of harm if it waits a few minutes. It can feel like a meaningful request because it affects the resident's day, yet it does not compare to a breathing emergency.

C) Request for a magazine

Getting a magazine is a comfort and activity request with no time pressure. It is easy to want to please the resident right away, but delaying it briefly causes no harm and it should be handled after urgent needs are met.

D) Help arranging personal belongings

Organizing belongings is a non-urgent task that can be scheduled for later in the shift. It may seem important because it involves the resident's personal space, but it poses no immediate risk and should not take priority over a resident in distress.

Conclusion

On the exam, prioritize requests using the ABCs and the idea of immediate threat to life: breathing problems, chest pain, bleeding, and other sudden changes come first. Routine comfort, activity, and organizing tasks can wait until urgent needs are addressed, and the nurse should be notified right away about any resident with sudden severe shortness of breath.

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21. A resident becomes dizzy when standing for a transfer. What should the CNA do?

A. Assist the resident to a safe position and report the change

B. Tell the resident to continue standing

C. Leave the resident standing while obtaining supplies

D. Give the resident medication for dizziness

Answer: A. Assist the resident to a safe position and report the change

When a resident becomes dizzy during a transfer, the CNA should assist the resident to a safe position and report the change.

Dizziness on standing suggests the brain may not be getting enough blood flow, which raises the risk of fainting and falling. The CNA's first duty is to protect the resident from injury by lowering them to a chair, bed, or the floor in a controlled way and staying with them. After the resident is safe, the CNA reports the episode to the nurse so the cause can be evaluated and the care plan updated. This stays within CNA scope: provide immediate safety and communicate observations.

B) Tell the resident to continue standing

This seems helpful if the dizziness is expected to pass quickly, but keeping a dizzy resident upright increases the chance of a fall and injury. The CNA should never push a resident to keep standing when they report or show dizziness.

C) Leave the resident standing while obtaining supplies

Stepping away leaves a dizzy resident unsupported and at high risk of falling. Even a brief absence removes the person who could steady or lower the resident safely, so the resident must be secured first and never left alone while symptomatic.

D) Give the resident medication for dizziness

Giving medication is outside CNA scope and could cause harm, especially without an order or assessment. It may seem like a quick fix, but the CNA's role is to keep the resident safe and report the change so the nurse can decide on any treatment.

Conclusion

For any resident who becomes dizzy or unsteady, safety comes first: support and lower the resident to a safe position, stay with them, and report the change promptly. Remember that assessing, treating, and medicating are nurse responsibilities, while protecting the resident and communicating are core CNA duties.

22. A resident wants to choose which shirt to wear but needs assistance dressing. What should the CNA do?

A. Offer choices and allow the resident to participate as much as possible

B. Choose the clothing without asking

C. Tell the resident there is no time for choices

D. Dress the resident without explanation

Answer: A. Offer choices and allow the resident to participate as much as possible

Offering choices and allowing the resident to participate as much as possible respects the resident's right to make personal decisions.

Respecting a resident's rights means honoring their preferences in daily care, even when they need help. Choosing what to wear is a personal decision, and needing assistance with dressing does not remove that right. The CNA should present a few realistic options, let the resident pick, and encourage them to do whatever parts of dressing they can manage safely. This supports dignity, independence, and self-determination while still completing the task.

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B) Choose the clothing without asking

Taking over the decision may seem efficient, but it removes the resident's voice in a matter that is theirs to decide. Even when care is rushed, the resident keeps the right to make personal choices.

C) Tell the resident there is no time for choices

Time pressure is real in care settings, but dismissing the resident's preference can feel disrespectful and undermines their rights. A brief set of two options usually takes very little time and preserves dignity.

D) Dress the resident without explanation

Silently dressing someone may feel faster, but it leaves the resident uninformed and uninvolved. Explaining and inviting participation keeps the resident engaged and supports their independence.

Conclusion

Remember that assistance with a task is not the same as taking over the decision. Whenever possible, offer choices and let the resident participate, because honoring personal preferences is a core part of resident rights.

23. A resident with dementia becomes frightened during evening care and tries to leave the room. What should the CNA do?

A. Remain calm, reduce stimulation, and use simple reassuring communication

B. Argue with the resident about where the resident is

C. Restrain the resident immediately

D. Speak loudly to force compliance

Answer: A. Remain calm, reduce stimulation, and use simple reassuring communication

Remain calm, reduce stimulation, and use simple reassuring communication to help the resident feel safe.

When a resident with dementia becomes frightened, the brain is having trouble making sense of the environment, so the fear feels very real. A calm voice, less noise and activity, and short, simple, reassuring words help lower that fear and let the resident settle. This approach respects the resident's dignity and stays within the CNA's scope of practice by focusing on safety, comfort, and redirection rather than control.

B) Arguing about where the resident is

Correcting or arguing with a frightened resident can increase confusion and agitation, because the resident's experience feels true to them in that moment. It may seem tempting to explain reality, but reasoning usually escalates distress instead of easing it.

C) Restraining the resident immediately

Physical restraint is not a first response and can cause injury, panic, and loss of dignity; it also falls outside what a CNA may do without proper orders and training. It may feel like the fastest way to keep the resident safe, but calming measures and reducing stimulation come first.

D) Speaking loudly to force compliance

Raising your voice can sound threatening and add to the resident's fear, making agitation worse. It may seem like a way to be heard, but a softer, slower tone is more effective with someone who is frightened.

Conclusion

For a frightened resident with dementia, stay calm, lower stimulation, and use simple reassurance. Avoid arguing, restraints, and loud demands, and remember that safety and dignity guide every action.

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24. A resident attempts to get out of bed without assistance despite having a known fall risk. What should the CNA do?

A. Provide immediate assistance and follow the resident's care plan and safety measures

B. Tell the resident to stay in bed and walk away

C. Physically force the resident back into bed

D. Remove the resident's call light

Answer: A. Provide immediate assistance and follow the resident's care plan and safety measures

Provide immediate assistance and follow the resident's care plan and safety measures.

When a resident with a known fall risk tries to get out of bed without help, the CNA should respond right away, stay with the resident, and assist in a safe way while following the care plan. The care plan may include things like bed alarms, non-skid footwear, keeping the bed low, or scheduled toileting and rounding. Assisting promptly meets the resident's need, protects them from a fall, and respects their dignity. The CNA should also report the attempt to the nurse so the care plan can be reviewed and updated if needed.

B) Tell the resident to stay in bed and walk away

Leaving a resident alone when they are already trying to get up removes the supervision that prevents a fall. This choice may seem quick and simple, but residents with confusion or urgency may not be able to follow the instruction, and walking away leaves them unattended at the moment of highest risk.

C) Physically force the resident back into bed

Using force can injure the resident or the CNA and can be considered a form of restraint, which is outside the CNA's scope. This option may seem like a fast way to keep the resident in bed, but safe care relies on gentle redirection, meeting the resident's need, and following the care plan rather than physical force.

D) Remove the resident's call light

The call light is the resident's way to ask for help, and taking it away increases the chance they will try to get up alone. This choice may seem like a way to stop the resident from calling out, but it takes away a key safety tool and does not address the reason the resident is trying to get out of bed.

Conclusion

For a resident at risk for falls, respond immediately, assist safely, and follow the care plan. Never use force, ignore the resident, or remove safety devices, and report the incident to the nurse so the plan of care stays effective.

25. A resident reports burning during urination that was not present previously. What should the CNA do?

A. Report the new symptom to the nurse

B. Tell the resident to drink less water

C. Diagnose a urinary infection

D. Give an antibiotic

Answer: A. Report the new symptom to the nurse

Reporting the new symptom to the nurse is the correct action.

Burning during urination that was not there before is a new symptom and may point to a urinary tract infection or another problem. A CNA's role is to observe and report changes to the licensed nurse, who can assess the resident, decide what is needed, and notify the provider. Reporting promptly helps the resident get proper care and supports infection control by catching possible infections early.

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B) Tell the resident to drink less water

Reducing fluids does not help burning with urination and can actually concentrate urine and worsen discomfort. This option may seem helpful because fluids are sometimes linked to urination, but limiting water is not a safe or appropriate response to a new symptom.

C) Diagnose a urinary infection

Making a diagnosis is outside the CNA scope of practice. Only a licensed provider can diagnose an infection after proper assessment and testing. This option may seem reasonable because the symptom sounds like an infection, but the CNA's job is to report, not diagnose.

D) Give an antibiotic

CNAs do not prescribe or give medications without a specific order and proper training. Giving an antibiotic on your own is unsafe and outside the role. This choice may seem tempting as a way to fix the problem quickly, but treatment decisions belong to the provider and nurse.

Conclusion

Remember that CNAs observe, report, and document changes in a resident's condition. When a new symptom appears, tell the nurse right away and let the licensed team handle assessment and treatment.

26. A resident becomes angry and begins speaking loudly during care. What is the best CNA response?

A. Remain calm, listen to the concern, and try to identify the resident's immediate need

B. Argue until the resident agrees

C. Speak louder than the resident

D. Leave without reporting the behavior

Answer: A. Remain calm, listen to the concern, and try to identify the resident's immediate need

Remaining calm, listening to the resident's concern, and identifying the immediate need is the best response when a resident becomes angry and speaks loudly during care.

When a resident becomes angry, the CNA's calm presence helps lower the emotional temperature rather than escalate it. Listening shows respect and gives the resident a chance to express what is bothering them. Anger often signals an unmet need, such as pain, fear, embarrassment, hunger, or feeling rushed, so the CNA should try to identify that need and respond within scope. If the behavior continues or safety is at risk, the CNA should stay safe and report to the charge nurse.

B) Argue until the resident agrees

Arguing with an angry resident tends to escalate the situation and damage trust. It may feel tempting to correct a resident who seems unreasonable, but the CNA's role is to de-escalate and support, not to win a disagreement.

C) Speak louder than the resident

Raising your voice can feel like a challenge or threat and may make the resident angrier. It might seem like a way to be heard, but matching volume usually increases tension instead of calming it.

D) Leave without reporting the behavior

Walking away without reporting leaves the resident's need unaddressed and keeps important information from the care team. It may seem like a quick way to avoid conflict, but the CNA is responsible for reporting changes in behavior and any safety concerns.

Conclusion

For test-takers, remember that calm listening and identifying the resident's need is the standard CNA approach to anger. Avoid arguing, raising your voice, or leaving without reporting, and always communicate concerns to the care team.

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27. A resident asks the CNA to change the prescribed oxygen flow rate because the resident feels short of breath. What should the CNA do?

A. Notify the nurse immediately and follow the established oxygen order and care plan

B. Change the flow rate independently

C. Turn the oxygen off

D. Tell the resident to wait until the next shift

Answer: A. Notify the nurse immediately and follow the established oxygen order and care plan

Notify the nurse immediately and follow the established oxygen order and care plan.

Oxygen flow rate is a prescribed medical order, and adjusting it falls outside the CNA's scope of practice. When a resident reports shortness of breath, the CNA should stay with the resident, check the oxygen equipment and tubing for kinks or disconnection, and report the change to the nurse right away. The nurse can assess the resident and contact the provider if the order needs to change. Following the existing order keeps the resident safe and respects the boundaries of the CNA role.

B) Change the flow rate independently

Turning the dial may seem like a quick way to relieve the resident's discomfort, but the flow rate is set by a provider's order. Changing it without authorization can cause harm, such as too little oxygen or oxygen toxicity, and it goes beyond what a CNA is trained and permitted to do.

C) Turn the oxygen off

Stopping oxygen could quickly worsen a resident who is already short of breath and may cause serious harm. This option may feel like a way to reset the situation, but any change to oxygen therapy must come from the nurse or provider.

D) Tell the resident to wait until the next shift

Shortness of breath is a change in condition that needs prompt attention, not a delay. Passing the concern to the next shift leaves the resident uncomfortable and at risk, and it does not fulfill the CNA's duty to report changes to the nurse.

Conclusion

Remember that oxygen flow rate is a prescribed order, so the CNA's job is to observe, keep the resident safe, and report changes to the nurse promptly rather than adjusting therapy independently.

28. A resident who spends most of the day in a wheelchair has intact skin but is at high risk for pressure injury. What should the CNA do?

A. Follow the care plan for repositioning and pressure relief

B. Wait until redness develops before taking action

C. Massage pressure areas vigorously

D. Keep the resident in the wheelchair continuously

Answer: A. Follow the care plan for repositioning and pressure relief

Follow the care plan for repositioning and pressure relief to protect the resident's intact skin.

Residents who sit in a wheelchair most of the day have constant pressure on the same areas, which reduces blood flow and can break down skin over time. The care plan is built around that resident's specific risk and tells the CNA how often to shift weight, reposition, and use pressure-relief methods, so following it prevents injury before it starts. Acting early on prevention is the core of good skin care in CNA scope of practice.

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B) Wait until redness develops

Redness is already a sign that tissue has been damaged by pressure, so waiting for it means the injury has begun. It can seem reasonable to watch for a visible warning, but prevention means acting before any warning appears.

C) Massage pressure areas vigorously

Vigorous rubbing over bony areas can damage fragile tissue and small blood vessels under the skin. Massage may feel like it would improve circulation, but over pressure points it adds friction and shear that increase harm.

D) Keep the resident in the wheelchair continuously

Staying in one position for long periods concentrates pressure on the same spots and raises the risk of breakdown. Keeping a resident settled may seem convenient or calming, but it works against skin health.

Conclusion

For a resident at high risk, prevention comes first: follow the care plan for repositioning and pressure relief, and report any skin changes promptly. Choose the option that protects intact skin rather than waiting for damage or using harsh measures.

29. A resident refuses breakfast. Which documentation is most appropriate?

A. Resident refused breakfast and stated that she was not hungry; nurse notified

B. Resident was being difficult

C. Resident does not care about nutrition

D. Resident is probably depressed

Answer: A. Resident refused breakfast and stated that she was not hungry; nurse notified

The most appropriate documentation objectively records that the resident refused breakfast, quotes her stated reason, and notes that the nurse was notified.

Good documentation is factual, specific, and objective. It states exactly what happened (the resident refused breakfast), records the resident's own words about why (she said she was not hungry), and shows that the charge nurse was informed so follow-up could occur. This gives the care team accurate information without judgment or assumptions, which supports continuity of care and protects both the resident and the aide.

B) Resident was being difficult

This phrasing is a personal judgment rather than an observed fact. It offers no useful clinical information about what actually happened or what the resident said, and it can unfairly label the resident. It may seem like a quick way to describe the situation, but documentation should describe behavior and words, not character.

C) Resident does not care about nutrition

This is an assumption about the resident's attitude that the aide cannot know from one refused meal. It skips the objective facts and could bias future caregivers. It may feel like a summary, but it is an opinion rather than a record of what was observed.

D) Resident is probably depressed

This is a clinical conclusion that is outside the CNA scope of practice. Aides report observations, not diagnoses. A single refused meal does not establish depression, and charting a guess could mislead the care team. It may seem caring to note a concern, but the proper approach is to document the facts and report concerns to the nurse.

Conclusion

For documentation questions, choose the option that is objective, specific, quotes the resident when possible, and shows that the nurse was notified. Avoid opinions, labels, and diagnoses, which are not part of the CNA role.

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30. A resident suddenly develops severe shortness of breath while walking. What is the priority action?

A. Stop the activity, keep the resident safe, and obtain immediate assistance

B. Encourage the resident to continue walking

C. Offer the resident a large meal

D. Leave the resident alone to rest

Answer: A. Stop the activity, keep the resident safe, and obtain immediate assistance

Stop the activity, keep the resident safe, and obtain immediate assistance.

Sudden severe shortness of breath is a medical emergency that can signal a heart attack, a blood clot in the lungs, or another life-threatening problem. The nurse aide's job is to halt whatever is causing strain, help the resident into a safe and comfortable position (often sitting upright), stay with them, and call for the nurse or emergency help right away. Prompt recognition and quick escalation give the resident the best chance of a good outcome.

B) Encourage the resident to continue walking

Continuing the activity adds physical demand at a moment when the resident's body is already struggling for oxygen, which can make the emergency worse. It may seem tempting to think movement or "walking it off" will help, but any exertion should stop when breathing becomes severely difficult.

C) Offer the resident a large meal

Eating, especially a large meal, does nothing to relieve severe shortness of breath and can increase discomfort, risk of choking, or aspiration when someone is struggling to breathe. Food may feel like a caring gesture, but it delays the urgent help the resident needs.

D) Leave the resident alone to rest

Leaving someone alone during sudden severe breathing difficulty is dangerous because their condition can worsen quickly and they may be unable to call for help. Rest may sound soothing, but the resident needs continuous observation and immediate professional assistance, not isolation.

Conclusion

When a resident suddenly has severe trouble breathing, remember: stop the activity, keep them safe and supervised, and get help immediately. Acting fast and staying with the resident are the core priorities in any breathing emergency.

31. Which statement accurately describes the Georgia nursing-home dining assistant role?

A. A dining assistant may provide feeding and hydration assistance to residents determined by nursing staff to be appropriate

B. A dining assistant may independently provide all nursing services

C. A dining assistant automatically replaces required nursing staff

D. A dining assistant may provide feeding assistance to residents with tube feedings

Answer: A. A dining assistant may provide feeding and hydration assistance to residents determined by nursing staff to be appropriate

A dining assistant may provide feeding and hydration assistance to residents determined by nursing staff to be appropriate.

The dining assistant role is a limited, delegated support role. Nursing staff assess each resident and decide who can safely receive eating and drinking help from a trained assistant. The assistant works under that direction and stays within the assigned feeding and hydration tasks, reporting changes or concerns to the nurse. This keeps residents safe and keeps the assistant inside the legal scope of the role.

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B) Independent provision of all nursing services

This option sounds appealing because dining assistants do help with meals, so it may seem like they do nursing work. However, the role is narrow and task-specific. Nursing services such as assessments, treatments, and medication administration require licensed nurses. A dining assistant cannot perform these independently, and doing so would exceed the role and could harm residents.

C) Automatically replaces required nursing staff

This may seem logical if a facility is short-staffed and wants extra help at meals. Still, the dining assistant supplements care rather than substituting for required nursing staff. Facilities must maintain required nursing coverage regardless of dining assistants. Treating the role as a replacement could leave residents without needed licensed oversight and violate staffing rules.

D) Feeding assistance for residents with tube feedings

Tube feedings look like feeding, so this option can be tempting. But tube feedings involve enteral nutrition and require nursing assessment and monitoring for complications. They are not the oral eating and drinking assistance the dining assistant role covers. Assigning tube feedings to a dining assistant would go beyond the role and risk resident safety.

Conclusion

Remember that the dining assistant role is limited to feeding and hydration help for residents the nursing staff have approved. The assistant works under nursing direction and does not take over nursing services, replace required staff, or manage tube feedings.

32. Which action is most effective for reducing the spread of microorganisms during routine resident care?

A. Perform hand hygiene at appropriate times

B. Wear gloves during every resident interaction

C. Keep the resident's door closed

D. Use antibiotics whenever a resident has a fever

Answer: A. Perform hand hygiene at appropriate times

Performing hand hygiene at the appropriate times is the single most effective action for reducing the spread of microorganisms during routine resident care.

Microorganisms are most often carried from one place to another on the hands of caregivers. Cleaning hands at the right moments, such as before and after contact with a resident, after touching body fluids or contaminated items, and after removing gloves, breaks the chain of transmission. This is a core infection-control practice that every CNA can perform consistently, and it protects both residents and staff.

B) Wearing gloves during every resident interaction

Gloves are a barrier for specific tasks involving contact with blood, body fluids, or contaminated surfaces, but they are not a substitute for clean hands. Wearing gloves for every interaction can create a false sense of protection, and hands still need hygiene before donning and after removing gloves. Gloves can also carry germs from one surface to another if they are not changed at the right times.

C) Keeping the resident's door closed

Closing a door may be part of certain isolation precautions, but it does not clean hands or stop organisms from moving between residents on a caregiver's hands. It may seem protective because it limits contact, yet it does little for routine transmission and can interfere with monitoring and communication.

D) Using antibiotics whenever a resident has a fever

Antibiotics treat specific bacterial infections and are prescribed by a provider after assessment; they are not a routine infection-control measure and do not prevent spread between people. Giving or suggesting antibiotics is outside CNA scope. A fever has many causes, and unnecessary antibiotic use can cause harm and resistance.

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Conclusion

For test-takers, remember that hand hygiene at the right times is the foundation of infection control in every care setting. Gloves, closed doors, and medications each have a role in specific situations, but none replaces clean hands for preventing the spread of microorganisms.

33. A Georgia 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

The CNA should explain that administering medication independently is outside the CNA's authorized role and notify the nurse.

In Georgia, a CNA who is not a certified medication aide is not authorized to give medications on their own. Medication administration requires specific training, delegation, and legal authority that falls under the nurse's scope of practice. When asked to do something outside that scope, the safest and most professional response is to politely explain the limit of the role and report the request to the supervising nurse so the patient still receives the medication on time. This protects the patient, the CNA, and the facility.

B) Administer it because the nurse is busy

A busy nurse does not change the legal limits of the CNA role. This option is tempting because CNAs want to be helpful and keep care moving, but giving medication without authorization can cause serious harm and puts the CNA's certification at risk.

C) Ask another CNA to administer it

Passing the task to a coworker does not make it allowed. If the CNA is not a certified medication aide, the other CNA likely is not either, and this simply spreads an unsafe practice. It may seem like a quick workaround, but it does not solve the underlying scope problem.

D) Hide the medication until the nurse returns

Concealing medication delays the patient's treatment and could lead to a missed dose or other harm. This option might feel like avoiding conflict, but it interferes with care and does not address the request properly. The right move is open communication with the nurse.

Conclusion

Know your scope of practice and speak up when a task falls outside it. Explaining the limit and notifying the nurse keeps the patient safe and follows the rules for CNA practice.

34. What is the minimum training time specified in current Georgia nursing-home rules for a dining assistant training program?

A. 16 hours

B. 4 hours

C. 8 hours

D. 24 hours

Answer: A. 16 hours

The minimum training time specified in current Georgia nursing-home rules for a dining assistant training program is 16 hours.

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Georgia nursing-home regulations set a defined training standard for dining assistants so that staff who help residents during meals understand safe feeding practices, positioning, and how to support residents who need assistance eating. A 16-hour program gives enough time to cover both classroom instruction and supervised practice, which helps protect residents from choking and other mealtime risks. Knowing this specific number is part of understanding how facilities in Georgia prepare unlicensed staff for dining support within CNA scope of practice.

B) 4 hours

A four-hour session feels manageable and may seem like enough for a simple task, but it falls far short of the training time Georgia requires for dining assistants. This amount would not allow for the instruction and supervised practice needed to safely assist residents at meals.

C) 8 hours

Eight hours is a common length for short in-service trainings, so it can look plausible. However, it does not match the minimum training time set in Georgia nursing-home rules for dining assistant programs.

D) 24 hours

Twenty-four hours sounds thorough and may appeal as a cautious, safety-focused answer. Even so, it exceeds the minimum specified in the Georgia rules, which set the requirement at a lower number of hours.

Conclusion

Remember that Georgia nursing-home rules require a minimum of 16 hours for dining assistant training. When a question asks for a specific regulatory number, recall the exact figure rather than choosing the option that merely sounds reasonable.

35. Which topic is specifically included in Georgia nursing-home dining assistant training?

A. Recognizing changes in residents that are inconsistent with their normal behavior

B. Prescribing medications

C. Diagnosing swallowing disorders

D. Performing independent nursing assessments

Answer: A. Recognizing changes in residents that are inconsistent with their normal behavior

Recognizing changes in residents that are inconsistent with their normal behavior is a key topic in Georgia nursing-home dining assistant training.

Dining assistants in Georgia nursing homes receive specialized training that includes monitoring residents during meals and recognizing any changes that may indicate a problem, such as difficulty eating, changes in appetite, or unusual behavior. This training helps them provide safe and effective support while knowing when to report concerns to the nursing staff. The other options involve tasks that are outside the scope of a dining assistant and require professional licensure or advanced training.

B) Prescribing medications

Prescribing medications is a responsibility of licensed healthcare providers such as physicians or nurse practitioners. Dining assistants do not have the authority or training to prescribe medications, and this topic would not be part of their training.

C) Diagnosing swallowing disorders

Diagnosing swallowing disorders requires specialized clinical assessment by speech-language pathologists or other qualified professionals. Dining assistants may be trained to observe and report signs of swallowing difficulties, but they do not diagnose these conditions.

D) Performing independent nursing assessments

Independent nursing assessments are performed by licensed nurses, not dining assistants. Dining assistants may contribute observations, but they do not conduct formal nursing assessments. This topic is beyond the scope of their role.

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Conclusion

For CNA exam questions about dining assistant training, focus on the specific knowledge and skills that support safe dining and observation, such as recognizing changes in residents that are inconsistent with their normal behavior. Remember that dining assistants are not trained to prescribe medications, diagnose swallowing disorders, or perform independent nursing assessments.

36. A Georgia nursing-home dining assistant is asked to perform bathing for a resident. What should the dining assistant do?

A. Decline the task unless separately qualified as a nurse aide or licensed nurse

B. Perform the bath because feeding assistants can provide all personal care

C. Ask the resident to perform the bath independently

D. Perform the bath without reporting it

Answer: A. Decline the task unless separately qualified as a nurse aide or licensed nurse

A dining assistant should decline the bathing task unless separately qualified as a nurse aide or licensed nurse.

In Georgia, the dining assistant role is limited to supporting meals and feeding residents. Bathing is personal care that falls within the nurse aide or licensed nurse scope, so a dining assistant who has not completed that separate training and qualification should not perform it. The safe and appropriate action is to politely decline and let the supervising nurse know so the task can be assigned to qualified staff. This protects the resident's dignity and safety and keeps the assistant within legal and facility limits.

B) Feeding assistants can provide all personal care

This option sounds helpful because feeding assistants do work closely with residents during meals, which can make their role seem broader than it is. However, feeding assistance training does not cover bathing or other personal care skills, so performing a bath would go beyond the assistant's preparation and legal scope.

C) Ask the resident to perform the bath independently

This may seem like a way to avoid overstepping, but it shifts a care task onto the resident. Residents in a nursing home are entitled to have personal care provided by qualified staff, and asking them to bathe alone could risk a fall, skin problems, or embarrassment. Declining and reporting is the proper step.

D) Perform the bath without reporting it

This might feel like the easiest way to avoid conflict, but doing an unqualified task quietly hides a scope-of-practice problem. It also removes the chance for the nurse to arrange proper care and could put the resident at risk. Transparency and reporting are essential parts of safe CNA practice.

Conclusion

Know your role limits and speak up when asked to do something outside your training. Declining and reporting keeps residents safe and keeps you within your legal scope of practice.

37. Which statement about the Georgia Certified Medication Aide role is accurate?

A. A certified medication aide must be a Georgia CNA in good standing and meet the separate medication-aide requirements

B. Every CNA is automatically listed as a certified medication aide

C. A nursing-home employee becomes a medication aide after orientation

D. A family member can place a CNA on the medication aide registry

Answer: A. A certified medication aide must be a Georgia CNA in good standing and meet the separate medication-aide requirements

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A certified medication aide must be a Georgia CNA in good standing and meet the separate medication-aide requirements.

In Georgia, the medication aide role is a separate credential layered on top of the CNA credential. A person must first hold an active CNA certification without discipline problems, then complete the additional medication-aide training and testing required by the state. This protects residents because medication tasks carry higher risk than basic nursing care, so the state verifies both the underlying CNA status and the extra medication-specific preparation before anyone is allowed to pass medications. Knowing this helps a CNA understand that the medication aide title is earned through a defined pathway, not assumed from a job title or a single orientation.

B) Automatic listing for every CNA

Being a CNA and being a medication aide are two distinct credentials with different training and testing requirements. It may seem convenient to assume that one certification covers the other, but the state keeps them separate so that only aides with verified medication training perform those tasks.

C) Medication aide after orientation

Facility orientation teaches policies, routines, and workplace expectations, but it does not grant a state credential. A nursing-home employee who only attends orientation has not completed the medication-aide education and competency requirements, so this path does not create a lawful medication aide.

D) Family member placing a CNA on the registry

Registries are maintained by the state based on verified training and testing, not by requests from relatives. A family member has no authority to add anyone to a state registry, and allowing that would bypass the safeguards meant to protect residents from unqualified medication administration.

Conclusion

Remember that medication aide status in Georgia is a separate, earned credential built on an active, unencumbered CNA certification plus additional state-required training and testing. When a question describes shortcuts like automatic listing, orientation alone, or family requests, those routes skip the verification steps that protect residents.

38. A resident wants to make a complaint about care. What is the CNA's most appropriate response?

A. Help the resident access the appropriate complaint or grievance process

B. Tell the resident complaints are not permitted

C. Discourage the resident from reporting the concern

D. Threaten to withhold care

Answer: A. Help the resident access the appropriate complaint or grievance process

Helping the resident access the appropriate complaint or grievance process respects the resident's right to voice concerns.

Residents have a legal and ethical right to make complaints about their care without fear of retaliation. When a resident wants to raise a concern, the CNA should support that right by helping the resident find and use the facility's grievance process, which may include connecting them with a social worker, ombudsman, or charge nurse. Supporting the resident in this way protects dignity, promotes quality improvement, and stays within the CNA's scope of practice by facilitating access rather than deciding the outcome of the complaint.

B) Telling the resident complaints are not permitted

This response denies a fundamental resident right and could be seen as intimidation. It may seem like a way to keep things calm on the unit, but residents are protected when they speak up about their care, and blocking complaints undermines trust and safety.

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C) Discouraging the resident from reporting the concern

Discouraging a resident may feel like a way to avoid conflict or protect staff, but it silences a legitimate concern and can allow problems to continue. Residents need encouragement to use formal channels so their issues are documented and addressed.

D) Threatening to withhold care

Threatening to withhold care is a form of retaliation and a serious violation of resident rights. It might be tempting to think a threat would end the complaint quickly, but this behavior is abusive, unprofessional, and never acceptable in any care setting.

Conclusion

Residents have the right to complain without fear of retaliation, and the CNA's role is to help them access the proper grievance process. Remember that supporting a resident's voice is part of person-centered care and protects both the resident and the care team.

39. A resident has a prescribed therapeutic diet, but the meal delivered does not match the resident's care plan. What should the CNA do?

A. Hold the meal and notify the appropriate nurse or dietary staff according to facility procedure

B. Tell the resident to eat the meal anyway

C. Change the diet independently

D. Discard the meal without reporting the problem

Answer: A. Hold the meal and notify the appropriate nurse or dietary staff according to facility procedure

Hold the meal and notify the appropriate nurse or dietary staff according to facility procedure.

Therapeutic diets are ordered for specific clinical reasons, such as diabetes, heart disease, kidney problems, or food allergies, so a meal that does not match the care plan could put the resident at risk. The CNA's role is to protect the resident by not serving the wrong tray and by reporting the mismatch promptly through the proper chain of command. Holding the meal prevents harm while the nurse or dietary staff verify the order and arrange the correct food, and following facility procedure keeps everyone informed and the resident safe.

B) Tell the resident to eat the meal anyway

Serving a tray that does not match the prescribed diet can lead to serious problems, such as unsafe blood sugar levels, fluid or sodium overload, or an allergic reaction. It may seem tempting to avoid delaying the resident's meal, but the CNA does not have the authority to override a prescribed diet, and the resident's safety comes first.

C) Change the diet independently

Diet orders are part of the medical plan of care and can only be changed by the provider, often with input from the dietitian. A CNA who alters a diet independently is acting outside the scope of practice and could cause harm. It may feel like a quick fix, but the right step is to report the problem so the appropriate staff can address it.

D) Discard the meal without reporting the problem

Throwing the tray away without telling anyone leaves the resident without food and hides a problem that needs to be corrected, such as a dietary error or a documentation mistake. It may seem like a way to remove the wrong food, but silence means the resident may go hungry and the same mistake can happen again. Reporting the issue is essential.

Conclusion

When a meal does not match the prescribed therapeutic diet, hold the tray and notify the nurse or dietary staff according to facility procedure. Never serve, change, or discard a diet tray on your own, because protecting the resident and reporting the mismatch is the CNA's responsibility.

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40. A CNA accidentally touches a clean supply with gloves contaminated during toileting care. What should the CNA do?

A. Remove the contaminated gloves, perform hand hygiene, and follow facility procedure for the contaminated supply

B. Return the supply to the clean storage area

C. Wipe the gloves and continue

D. Use the supply for another resident

Answer: A. Remove the contaminated gloves, perform hand hygiene, and follow facility procedure for the contaminated supply

Remove the contaminated gloves, perform hand hygiene, and follow facility procedure for the contaminated supply.

Gloves worn during toileting care are contaminated and can spread germs to anything they touch. Once a clean supply has been touched with those gloves, the supply is no longer considered clean. The safe response is to take off the gloves right away, clean your hands, and then handle the item according to your facility's policy for contaminated supplies, such as bagging it for cleaning, reprocessing, or disposal. This protects residents, staff, and the environment from cross-contamination.

B) Return the supply to the clean storage area

Putting the item back with clean supplies would spread germs to other items and to anyone who later uses them. It may seem like a quick way to avoid waste, but a supply touched by contaminated gloves can no longer be treated as clean.

C) Wipe the gloves and continue

Wiping gloves does not make them clean or safe to use. Gloves are meant to be removed and discarded after contamination, and wiping them can spread germs to the hands and to whatever is touched next. Continuing care with wiped gloves puts residents at risk.

D) Use the supply for another resident

Using the contaminated supply on another resident would directly transfer germs from the toileting care to that person, raising the risk of infection. It may seem practical to avoid throwing the item away, but resident safety always comes first.

Conclusion

When contaminated gloves touch a clean item, that item is no longer clean. Remove the gloves, perform hand hygiene, and follow facility policy for handling the contaminated supply so germs do not spread to others.

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