KENTUCKY CERTIFIED NURSE AIDE (CNA) PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. When should documentation be recorded?

A. after the oral report is given.

B. before care is provided.

C. at the end of the shift.

D. only when asked.

2. When documenting fluid intake and output, which unit should be used?

A. Cups.

B. Liters.

C. Milliliters.

D. Pounds.

3. What general duties does a Kentucky CNA perform independently, and what tasks require nurse delegation or supervision?

A. Can perform any medical treatment without supervision.

B. Cannot perform any personal care tasks.

C. Independently perform activities of daily living, hygiene assistance, feeding support, simple mobility tasks, and observation reporting; tasks requiring nurse delegation or supervision include administration of medications, injections, and other treatments beyond basic care.

D. Needs a physician to authorize basic hygiene.

4. In a full bed bath, which area is washed after the arms?

A. Chest

B. Abdomen

C. Shoulders

D. Neck

5. Liability means what?

A. Someone can be held harmless from legal action

B. Someone can be held responsible for harming someone else

C. A policy for facility budgeting

D. An insurance plan for staff

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6. What should you do if you make a mistake in a chart?

A. Erase the entry completely.

B. Rewrite the entire chart.

C. Draw a single line through the error and initial and date.

D. Ignore the mistake.

7. What describes a care plan?

A. A schedule of meals and dietary restrictions

B. A policy for evaluating care quality

C. A list of daily activities

D. A written plan for each resident created by a nurse; outlines the steps taken by the staff to help the resident reach his or her goals

8. Which term describes the improper or illegal use of a person's money or assets by another person, such as a caregiver?

A. Domestic violence

B. Assault

C. Financial abuse

D. Battery

9. Which term describes the act of failing to act or provide necessary care, leading to an unintended injury?

A. Neglect

B. The law

C. Negligence

D. Ombudsman

10. Which role is listed as part of the chain of command?

A. Administrator

B. MD

C. Assistant Director of Nursing

D. Minimum Data Set Coordinator

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Answers

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1. A
2. C
3. C
4. A
5. B
6. C
7. D
8. C
9. C
10. D

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Explanations

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1. When should documentation be recorded?

A. after the oral report is given.

B. before care is provided.

C. at the end of the shift.

D. only when asked.

Documentation should be recorded after you complete the care and have the facts fresh, typically right after the oral report is given during shift handoff. This timing makes sure the record accurately reflects what was observed, what actions were taken, and how the patient responded, with the correct date and time and your signature. If you document before care, you risk recording something that may not match what actually happened. Waiting until the end of the shift can lead to forgotten details and incomplete information, and documenting only when asked delays important handoffs. Recording after the oral report supports clear, timely communication and a reliable record for the care team.

2. When documenting fluid intake and output, which unit should be used?

A. Cups.

B. Liters.

C. Milliliters.

D. Pounds.

Using a consistent metric unit for documenting fluid intake and output ensures precision in tracking a patient's balance. Milliliters provide small, exact measurements and are the standard in healthcare documentation, which makes it easy to calculate totals and detect deficits or excess. Larger units like liters can hide small variations, and cups vary in size, leading to inconsistent records. Pounds measure weight, not volume, so they're not appropriate for fluids. For example, recording 250 mL of intake and 350 mL of output gives a clear deficit of 100 mL; if you used cups or pounds, you'd need conversions that can introduce errors. Therefore, milliliters are the best choice for documenting I&O.

3. What general duties does a Kentucky CNA perform independently, and what tasks require nurse delegation or supervision?

A. Can perform any medical treatment without supervision.

B. Cannot perform any personal care tasks.

C. Independently perform activities of daily living, hygiene assistance, feeding support, simple mobility tasks, and observation reporting; tasks requiring nurse delegation or supervision include administration of medications, injections, and other treatments beyond basic care.

D. Needs a physician to authorize basic hygiene.

In Kentucky, CNAs work under the supervision of a licensed nurse and have a defined, limited scope of practice. They can perform many routine, hands-on care tasks independently, including helping with activities of daily living (bathing, dressing, grooming), providing hygiene assistance, assisting with feeding, helping with simple mobility tasks, and observing and reporting changes in the patient's condition to the nurse. Tasks that require nurse delegation or direct supervision include administering medications, giving injections, and other treatments beyond basic care. These are not within the CNA's independent duties and must be authorized and overseen by a licensed nurse. This distinction ensures patient safety and that skilled tasks are performed by appropriately trained personnel. So, CNAs handle the basic, everyday care and observation on their own, while more advanced or potentially higher-risk procedures must be delegated and supervised by a nurse.

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4. In a full bed bath, which area is washed after the arms?

A. Chest

B. Abdomen

C. Shoulders

D. Neck

In a full bed bath, the cleaning follows a top-to-bottom, orderly flow that moves from areas touched most to create a smooth, continuous routine while keeping the resident comfortable. After washing the arms, the next area on the trunk is the chest. This continuation makes sense because the sequence cleanly progresses along the upper body, going from the limbs to the torso before moving to the abdomen and legs. The neck and shoulders are typically addressed earlier in the bath, and the abdomen usually comes after the chest. So washing the chest right after the arms fits the common order.

5. Liability means what?

A. Someone can be held harmless from legal action

B. Someone can be held responsible for harming someone else

C. A policy for facility budgeting

D. An insurance plan for staff

Liability means being legally responsible for actions or omissions that cause harm to someone else. In a CNA role, this means your actions (or failures to act) could lead to legal accountability if they harm a patient, so you're responsible for following standards of care, documenting accurately, and reporting concerns to prevent harm. The other options describe protections or financial tools rather than responsibility for harm: being held harmless from legal action would mean protection from liability, while budgeting policies or insurance plans relate to finances, not the definition of liability.

6. What should you do if you make a mistake in a chart?

A. Erase the entry completely.

B. Rewrite the entire chart.

C. Draw a single line through the error and initial and date.

D. Ignore the mistake.

In charting, the goal is to keep a complete, auditable record and clearly show any corrections. If a mistake is made, you don't erase or rewrite the entry because that hides history and can look like tampering. You also shouldn't ignore the error, since that leaves inaccurate information in the record. The proper method is to draw a single line through the mistake so the original entry remains legible, then initial and date the correction and add the correct information in the proper place (or follow your facility's policy for making corrections). This preserves the original data, makes the correction traceable, and maintains patient safety and accountability.

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7. What describes a care plan?

A. A schedule of meals and dietary restrictions

B. A policy for evaluating care quality

C. A list of daily activities

D. A written plan for each resident created by a nurse; outlines the steps taken by the staff to help the resident reach his or her goals

A care plan is an individualized, written plan for each resident created by a nurse that outlines the steps the staff will take to help the resident reach his or her goals. It follows the nursing process—assessing the resident, identifying problems, setting specific goals, choosing interventions, and deciding how progress will be evaluated—so every member of the care team knows what to do and why. This plan ensures coordinated, consistent care and communication among staff, and it is updated as the resident's needs change. It's not just a meal schedule, a quality-evaluation policy, or a simple list of activities.

8. Which term describes the improper or illegal use of a person's money or assets by another person, such as a caregiver?

A. Domestic violence

B. Assault

C. Financial abuse

D. Battery

Financial abuse describes the improper or illegal use of a person's money or assets by someone else, such as a caregiver. This includes taking funds, forging signatures, pressuring the person to sign financial documents, misusing a power of attorney, or directing benefits for the caregiver's own use. It targets a person's financial resources and is a form of abuse seen in care settings, especially with vulnerable adults who rely on others. The other terms describe different harms—domestic violence involves physical or coercive harm within intimate relationships, and assault or battery refer to physical injury—so they don't capture the financial exploitation involved. In practice, look for signs like unexpected withdrawals, new signatures on accounts, missing money or valuables, unpaid bills, or pressure to give away assets, and report suspected cases per policy.

9. Which term describes the act of failing to act or provide necessary care, leading to an unintended injury?

A. Neglect

B. The law

C. Negligence

D. Ombudsman

Negligence means failing to exercise the level of care that a reasonably prudent person would in a given situation, and when that failure leads to unintended harm, it's described as negligence. In a care setting, this covers situations where a caregiver doesn't act or provide necessary care, and the resident is harmed as a result. The term "neglect" can refer to the broader act of not providing care, but the specific idea of harm caused by not meeting the expected standard of care is best captured by negligence. The other options don't describe this failure to act with the resulting injury: the law is the system itself; an ombudsman is an advocate for residents; neglect describes the failing to provide care, not the formal breach of duty that results in harm.

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10. Which role is listed as part of the chain of command?

A. Administrator

B. MD

C. Assistant Director of Nursing

D. Minimum Data Set Coordinator

In a facility, the chain of command shows who has authority, who supervises whom, and how communication flows for resident care and operations. The Minimum Data Set Coordinator is responsible for coordinating the resident assessments (the MDS), which determine care plans, regulatory reporting, and quality measures. Because this role directly influences daily care decisions, care planning, and compliance, it sits within the nursing/administrative leadership structure and has a defined reporting line to the Director of Nursing or Administrator. That placement makes the MDS Coordinator part of the formal chain of command. The other roles exist in the organization, but the MDS Coordinator's position is specifically tied to the supervision and flow of nursing care decisions across residents.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://kycna.examzify.com

We wish you the very best on your exam journey. You've got this!

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