

NORTH CAROLINA CNA WRITTEN PRACTICE EXAM (SAMPLE)

STUDY GUIDE



Prepare with structure. Pass with confidence



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

SAMPLE

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.

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!

Questions

SAMPLE

- 1. What is the primary goal of a CNA when assisting with daily living activities?**
 - A. To make decisions for the residents
 - B. To promote independence and dignity
 - C. To complete tasks as quickly as possible
 - D. To oversee other staff members
- 2. What information should be documented after patient care?**
 - A. Only the time of care provided
 - B. Care provided, patient's response, and any changes in condition
 - C. The name of the CNA who provided care
 - D. Details of conversations with the patient's family
- 3. How frequently should you check on restrained residents?**
 - A. Every hour
 - B. Every 30 minutes
 - C. Every 15 minutes
 - D. Every 5 minutes
- 4. What does the term "personal protective equipment" (PPE) refer to?**
 - A. Clothing worn for formal occasions
 - B. Gear worn to protect against health and safety risks, such as gloves, masks, and gowns
 - C. Equipment used for patient therapy
 - D. Medical tools for diagnosis
- 5. What are signs typical of a urinary tract infection (UTI)?**
 - A. Light-colored urine and absence of pain
 - B. Dark urine, odorous urine, pain, and/or confusion
 - C. Frequent urination but no pain
 - D. Clear urine and mild discomfort

- 6. Which behavior is critical for establishing trust with residents?**
- A. Being judgmental
 - B. Listening actively
 - C. Maintaining strict professionalism
 - D. Being overly friendly
- 7. Who is responsible for developing the resident's care plan that CNAs will follow?**
- A. Nursing assistant
 - B. Registered nurse or Licensed practical nurse
 - C. Medical doctor
 - D. Patient's family
- 8. Why is it important for a CNA to maintain patient confidentiality?**
- A. It is not necessary in most cases
 - B. To protect patient privacy and rights
 - C. So staff can discuss openly
 - D. To facilitate communication with family only
- 9. When communicating with residents, which type of question is preferable?**
- A. Yes/no questions
 - B. Closed-ended questions
 - C. Open-ended questions
 - D. Leading questions
- 10. What should a CNA do if they suspect abuse?**
- A. Confront the alleged abuser directly
 - B. Ignore the signs of abuse
 - C. Report it according to facility policy and alert a supervisor
 - D. Discuss it with other residents

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What is the primary goal of a CNA when assisting with daily living activities?

- A. To make decisions for the residents
- B. To promote independence and dignity**
- C. To complete tasks as quickly as possible
- D. To oversee other staff members

The primary goal of a CNA when assisting with daily living activities is to promote independence and dignity among residents. This approach aligns with the core values of patient-centered care, which emphasizes respect for individuals and their ability to maintain control over their own lives, even while requiring assistance. By encouraging residents to perform tasks on their own, CNAs help foster a sense of pride and self-worth, which is essential for their emotional well-being. Supporting independence also involves providing assistance in a manner that respects the personal preferences and abilities of each resident. This not only enhances their quality of life but also builds trust between the resident and the caregiver. Furthermore, promoting dignity ensures that residents feel valued and respected, which can have a positive impact on their overall health and happiness. The other options do not reflect best practices in caregiving. Making decisions for residents can undermine their autonomy, while completing tasks quickly may compromise the quality of care. Overseeing other staff members is outside the typical responsibilities of a CNA and does not contribute directly to the well-being of the residents.

2. What information should be documented after patient care?

- A. Only the time of care provided
- B. Care provided, patient's response, and any changes in condition**
- C. The name of the CNA who provided care
- D. Details of conversations with the patient's family

Documenting patient care is a critical aspect of the nursing assistant's responsibilities. When documenting, it is essential to include comprehensive information that reflects the care provided to the patient. This includes detailing the specific care administered, the patient's response to that care, and any changes in the patient's condition that may have occurred during or after the interaction. Including the care provided ensures that there is a clear record of what was done, which is vital for continuity of care and for other healthcare professionals who may be involved in the patient's treatment. Documenting the patient's response is crucial as it helps in assessing the effectiveness of the care provided and may indicate the need for potential adjustments to the care plan. Noting any changes in condition is equally important, as these could have significant implications for the patient's health and treatment moving forward. This comprehensive approach to documentation is essential for maintaining high standards of patient care and ensuring legal protection for healthcare providers. In contrast, simply noting the time of care provided, documenting only the caretaker's name, or detailing conversations with family members lacks the depth required for effective patient care documentation. This broader scope allows for better communication within the healthcare team and enhances the overall quality of patient care.

3. How frequently should you check on restrained residents?

- A. Every hour
- B. Every 30 minutes
- C. Every 15 minutes**
- D. Every 5 minutes

For residents who are restrained, checking on them every 15 minutes is essential for their safety and well-being. This frequent monitoring helps to ensure that the residents are not experiencing any distress or discomfort due to the restraints. It allows caregivers to assess their physical and emotional state, checking for any signs of pain, agitation, or other complications that may arise from prolonged restraint use. This level of vigilance is necessary because restraints can lead to serious issues such as pressure ulcers, restricted movement, and psychological effects like fear and anxiety. By conducting checks every 15 minutes, caregivers can promptly address any issues, assist with repositioning if needed, provide comfort, and ensure that the restraints are not causing harm. Regular assessments are a fundamental part of promoting the dignity and health of residents who may require restraints for their own safety or the safety of others.

4. What does the term "personal protective equipment" (PPE) refer to?

- A. Clothing worn for formal occasions
- B. Gear worn to protect against health and safety risks, such as gloves, masks, and gowns**
- C. Equipment used for patient therapy
- D. Medical tools for diagnosis

The term "personal protective equipment" (PPE) is specifically defined as gear worn to protect individuals from potential health and safety risks, particularly in healthcare settings. This includes items like gloves, masks, gowns, and face shields, which serve to minimize the chance of exposure to infectious materials and harmful substances during patient care or other health-related activities. The importance of PPE cannot be overstated, as it plays a crucial role in infection control and maintaining safety standards for both healthcare workers and patients. For example, gloves prevent direct contact with bodily fluids, masks limit the spread of respiratory droplets, and gowns protect clothing and skin from contamination. Contextually, other options do not accurately represent the definition of PPE. Clothing for formal occasions does not relate to health and safety risks, equipment used for patient therapy refers to therapeutic tools rather than protective gear, and medical tools for diagnosis concern instruments used to examine patients rather than personal protection against hazards. Therefore, the correct answer encompasses the vital role that PPE plays in safeguarding health and preventing the transmission of infections.

5. What are signs typical of a urinary tract infection (UTI)?

- A. Light-colored urine and absence of pain
- B. Dark urine, odorous urine, pain, and/or confusion**
- C. Frequent urination but no pain
- D. Clear urine and mild discomfort

The presence of dark, odorous urine, pain, and/or confusion are classic signs of a urinary tract infection (UTI). When the urinary tract is infected, the body's response often includes changes in the urine, which may appear darker due to the presence of bacteria or blood, and have a strong, unpleasant odor as a result of the infection. Pain, particularly during urination or in the lower abdomen, is another common symptom, caused by inflammation and irritation in the urinary tract. Additionally, confusion can occur, particularly in older adults, as UTIs can affect mental status due to factors like dehydration or the body's inflammatory response. Recognizing these signs is crucial for early intervention and treatment, preventing more serious complications that may arise if a UTI is left untreated. Other options describe symptoms that may not be typically associated with a UTI. For example, light-colored urine and absence of pain might indicate normal hydration and bladder function, while clear urine with mild discomfort could suggest other non-infectious issues. Frequent urination without pain could occur due to various reasons as well, but the additional symptoms present in the correct option paint a clearer picture of a UTI.

6. Which behavior is critical for establishing trust with residents?

- A. Being judgmental
- B. Listening actively**
- C. Maintaining strict professionalism
- D. Being overly friendly

Listening actively is critical for establishing trust with residents because it demonstrates that you value their thoughts and feelings. By actively engaging in conversations, you show that you are present and attentive to their needs, which fosters a sense of safety and respect. This behavior encourages residents to open up, share their concerns, and feel more comfortable in their environment. While maintaining professionalism is important, it needs to be balanced with a personal touch to avoid emotional distance. Being overly friendly can also blur the lines of professionalism, making it harder to maintain an appropriate caregiver-resident relationship. Being judgmental undermines trust completely, as it can make residents feel criticized or belittled, leading to a negative impact on their emotional well-being.

7. Who is responsible for developing the resident's care plan that CNAs will follow?

- A. Nursing assistant
- B. Registered nurse or Licensed practical nurse**
- C. Medical doctor
- D. Patient's family

The development of a resident's care plan is primarily the responsibility of a registered nurse or licensed practical nurse. These healthcare professionals possess the necessary training and expertise to assess a resident's health status and create a plan that addresses the individual needs and preferences of that resident. They consider various factors such as medical history, current health conditions, and any specific challenges the resident may be facing. The care plan serves as a roadmap for delivering consistent and personalized care; therefore, it is vital that a qualified nurse oversees this process. CNAs follow the care plan in their daily interactions with residents, ensuring that the care provided aligns with the goals set out by the nursing staff to promote the best possible outcomes for the residents. This collaborative approach ensures that the care delivered is both safe and effective. While other stakeholders like medical doctors and family members may provide input or support, it is ultimately the licensed nursing professionals who hold the responsibility for the comprehensive planning of care.

8. Why is it important for a CNA to maintain patient confidentiality?

- A. It is not necessary in most cases
- B. To protect patient privacy and rights**
- C. So staff can discuss openly
- D. To facilitate communication with family only

Maintaining patient confidentiality is essential for ensuring the protection of patient privacy and rights. This principle is rooted in ethical standards and legal regulations, such as HIPAA (Health Insurance Portability and Accountability Act), which mandate that healthcare providers safeguard personal health information. When a CNA respects confidentiality, it helps to foster trust between the patient and healthcare provider, encouraging patients to be open and honest about their health concerns without fear of judgment or disclosure. This trust is critical for effective care, as it allows for more accurate assessments and better treatment outcomes. Additionally, maintaining confidentiality upholds the patient's autonomy and dignity, giving them control over who has access to their personal information. Breaches of confidentiality can lead to significant consequences, such as emotional distress for the patient, legal repercussions for the healthcare provider, and a breakdown of the professional relationship. Thus, protecting patient information is vital to both ethical practices in healthcare and the overall integrity of the healthcare system.

9. When communicating with residents, which type of question is preferable?

- A. Yes/no questions
- B. Closed-ended questions
- C. Open-ended questions**
- D. Leading questions

Open-ended questions are preferable when communicating with residents because they encourage more comprehensive responses and promote conversation. This type of question allows individuals to express their thoughts, feelings, and experiences in their own words, fostering a deeper understanding between the caregiver and the resident. Open-ended questions can help build rapport and trust, as they show that the caregiver is genuinely interested in the resident's opinions and well-being. This approach can also uncover valuable insights into a resident's needs or preferences that might not be addressed by more restrictive questioning formats. By engaging residents in this way, caregivers can ensure they are providing personalized care that truly meets the individual's needs.

10. What should a CNA do if they suspect abuse?

- A. Confront the alleged abuser directly
- B. Ignore the signs of abuse
- C. Report it according to facility policy and alert a supervisor**
- D. Discuss it with other residents

When a CNA suspects abuse, the appropriate action is to report the situation according to facility policy and alert a supervisor. This protocol is in place to ensure the safety and well-being of the residents. By recognizing the seriousness of the situation and following established reporting procedures, the CNA helps initiate an investigation by trained professionals who are equipped to handle such allegations properly. This ensures that the issue is addressed in a way that protects the victim and allows for appropriate intervention. Taking this action also adheres to legal and ethical responsibilities related to patient care, as CNAs are mandated reporters. They are required to report any signs of abuse or neglect they observe, rather than attempting to resolve the situation independently or discussing it with others, which could compromise the investigation and the safety of the involved individuals.

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://northcarolinacna.examzify.com>

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

SAMPLE