ASF LONG-TERM CARE STANDARDS

Complete Reference — Base Standard + 2 Endorsements

Version 3.0 · 2026

Accréditation Sans Frontières · Paris, France · Geneva, Switzerland · Tbilisi, Georgia

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Foreword

This standard originates from a deliberate policy choice made in Georgia in 2014: to advocate for international healthcare accreditation rather than attempt to replace it. Working through the Public Health Institute of Georgia (PHIG, established 2011), its founders organized the country's first structured accreditation initiative — including expert missions by Joint Commission International — and carried this advocacy directly to Georgia's Ministry of Health over the following years.

That advocacy produced, in 2018, the first draft of a Georgian-adapted accreditation standard, and in 2020, the formal establishment of Accréditation Sans Frontières (ASF) as an international legal entity in Paris, alongside the ASF International Standards Council — the standing body responsible for developing and revising ASF's standards. The Council's methodology is directly informed by the World Health Organization's guideline development process, including WHO's use of the GRADE framework for weighing evidence certainty, adapted to the practical work of accreditation. ASF's founder has served since 2016 as a founding member of the UN Secretary-General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent, and ASF has been a member of the International Society for Quality in Health Care (ISQua) since 2023.

This advocacy also found regulatory validation in Georgian government policy requiring independent international accreditation of hospitals, formally implemented through Order №4/б (26 January 2023).

Consistent with the structure recognized across major international standards bodies, ASF's work spans four pillars: accreditation of organizations against its published standards, accreditation of the standards themselves through the International Standards Council's ongoing review, accreditation of the surveyors who conduct ASF's own assessments, and accreditation of the training that equips facilities and professionals to meet them, delivered through GMJ Academy. This standard has been developed and refined through consultation with practitioners across multiple continents, and every edition includes a Health & Migration endorsement grounded in WHO's Global Competency Standards for health workers serving refugees and migrants — a commitment ASF treats as non-negotiable. Consistent with ASF's founding principle of accreditation without borders, this standard is published in full and made freely available to any organization seeking to build accreditation capacity in its own country.

This, the third edition, is published in 2026. The ASF International Standards Council reviews and revises each standard on a three-year cycle.

About This Document

This is the ASF Long-Term Care complete standard — seven mandatory base standards covering the full resident journey in any residential long-term care facility, independent of ownership or model, plus two built endorsements layering onto that base: Medical Tourism and Health & Migration. No endorsement is ever issued alone — each is only assessed after the base standard is genuinely met in full.

Every criterion follows the same two-page structure established across ASF's standards: an assessment page (a facility self-assessment table, and exactly what an ASF assessor will independently check) and a guidance page (why the standard exists, what good and failure look like, how to implement from zero).

Every criterion carries at least one reference. Numbered references are formal, individually verified Vancouver-style citations; where a criterion instead reflects genuine professional consensus without one attributable paper, that is stated honestly rather than assigned an invented citation.

Immediately after this page is the Facility Classification chapter — the same four-type model already established for ASF's Hospital standard, adapted for long-term care facilities specifically: Crisis, Transitional, Small, or Standard.

Alignment With ISO 9001:2015

This standard's governance structure — Standard 7 — is deliberately built to reflect the core management principles of ISO 9001:2015, the international quality management system standard [7]. This is a statement of structural alignment, not a claim of certification: ISO 9001:2015 compliance is a formal status determined only through accredited external audit, which this document does not confer. The table below shows the mapping honestly, clause by clause.

ISO 9001:2015 CLAUSE	WHERE THIS STANDARD REFLECTS IT
Clause 4 — Context of the Organization	Not directly covered — outside this standard's clinical patient-safety scope.
Clause 5 — Leadership	7.1 — Leadership Is Real and Accountable
Clause 6 — Planning	3.4 (Risk Register) and 7.8 (Quality Objectives Are Set, Specific, and Tracked)
Clause 7 — Support	4.2 (Credentials), 7.4 (Records), 7.6 (Scope of Practice)
Clause 8 — Operation	Standard 4 (Care & Treatment) in full
Clause 9 — Performance Evaluation	7.7 — Leadership Reviews Overall Performance at Planned Intervals
Clause 10 — Improvement	7.5 (Incident Reporting) and 7.9 (Continual Improvement Process)

Facility Classification — Which Type of Long-Term Care Facility Are You?

Four Facility Types, Not One

The same four-category model built for ASF's Hospital standard applies here, with one deliberate change: Small is anchored to resident capacity, not bed count or staff count — the number of people actually living in the facility is what genuinely determines what a long-term care facility can realistically offer.

Standard (ST)

A fully resourced, functioning long-term care facility — full clinical support, dedicated activities and social programming, no adaptation needed.

Small (SM) — where staffing depth, not crisis or poverty, is the defining constraint

Fewer than 60 residents is the confirmed anchor — a genuine, externally established research threshold for small long-term care facilities, not ASF's own invented figure. A facility below this size is otherwise stable, but genuinely limited by scale in what it can offer.

Transitional (TR)

Real national resource or infrastructure limitation, no active conflict — the same World Bank-anchored logic used throughout ASF's standards.

Crisis (CR)

Active conflict or humanitarian emergency — overrides every other consideration, exactly as in the Hospital standard.

The Universal Floor

A small number of criteria apply in full, in every one of the four types, with no exceptions: correct resident identification, genuine hand hygiene, real informed consent — by the resident or their legal representative — dignity and non-discrimination, and — specific to long-term residential care — freedom from abuse and neglect, verified directly, not assumed from the absence of a complaint.

Which Type of Long-Term Care Facility Are You?

Answer these questions in order, top to bottom. The moment you answer YES, stop — that is your answer. If you reach the end still answering NO, you are Standard.

WORK DOWN THIS LIST. STOP AT YOUR FIRST YES.			
1	**Is your country in an active war, armed conflict, or a declared humanitarian emergency right now?** *This means fighting, displacement, or a declared emergency is actually happening now — not that things are generally difficult.*	☐ **YES → CR CRISIS**	☐ NO → next question
2	**Does your national government struggle badly to fund healthcare, or is national power or medicine supply unreliable — even though there is no war or crisis?** *This is about your country as a whole, not just your own facility.*	☐ **YES → TR TRANSITIONAL**	☐ NO → next question
3	**Does your facility have fewer than 60 residents, and is that small size the main reason you cannot offer certain services — for example, a dedicated activities director, an on-site physician, or a specialized dementia care unit?** *This applies even in a stable, well-funded country. The limit here is your own size, nothing else.*	☐ **YES → SM SMALL**	☐ NO → next question
If you answered NO to all three questions above: You are **STANDARD (ST)** — no crisis, no national constraint, and staffing depth is not holding you back.			

THIS IS ME
My type: ☐ **CR** ☐ **TR** ☐ **SM** ☐ **ST**

Example: A residential care home in Lebanon — no active conflict, so NO to question 1. National power and funding are genuinely unreliable, so YES to question 2. Stop there. This facility is TR.

Verified, not just accepted, on the assessor's visit. If reality is different from what you ticked, the classification is corrected on the spot.

Table of Contents

STANDARD 1

Admission & Resident Rights

MANDATORY

5 criteria

Standard 1.1 **NON-NEGOTIABLE** · *Standard 1: Admission & Resident Rights*

Admission Agreement Is Genuinely Understood, Not Just Signed

ASSESSMENT ASF-LTC-STD1-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.1
NON-NEGOTIABLE
L1

THE STANDARD

Admission Agreement Is Genuinely Understood, Not Just Signed

Before or at admission, the resident or their legal representative receives a genuine, plain-language explanation of the admission agreement's actual terms — services included, room configuration, facility-specific rules — with understanding verified, not just a signature obtained on a document handed over at a stressful, disorienting moment.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the resident or legal representative receive a genuine, plain-language explanation of the agreement, not just the document itself?** *A real explanation, not a document handed over for signature alone.* Doc: Admission agreement explanation record	YES	PARTIAL	NO
2	**Is understanding actively verified — for example, through teach-back — before the agreement is signed?** *Genuine verification, not assumed from a signature.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does the explanation specifically cover facility-specific characteristics and service limitations, not only generic terms?** *Specific to this facility, not a generic admission script.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Admission conversation observation*	Observes an actual admission conversation, or a re-creation of one, for genuine explanation and verification.
DOCUMENT *Agreement documentation review*	Reviews admission agreements for specific, facility-characteristic disclosure, not generic template language.
ASK *Family understanding interview*	Asks a resident or family member what they understood about the agreement's actual terms.

REFERENCES

[1] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require disclosure to a resident or potential resident, prior to admission, of the facility's specific characteristics and service limitations as part of a genuine admission agreement process.

Standard 1.1 · *Standard 1: Admission & Resident Rights*

Guidance & Learning

GUIDANCE ASF-LTC-STD1-v3.0

WHY THIS STANDARD EXISTS

Admission to a long-term care facility often happens during a genuinely difficult, emotionally overwhelming moment — a health crisis, a family decision made under pressure — and a signature obtained without real understanding isn't meaningful consent, it's paperwork. What the resident and family actually understand about the agreement matters as much as what the document technically says.

The evidence: [1] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require disclosure to a resident or potential resident, prior to admission, of the facility's specific characteristics and service limitations as part of a genuine admission agreement process.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine, plain-language explanation is given before or at admission.	✗ The agreement is handed over for signature with no real explanation.
✓ Understanding is actively verified, not assumed from a signature.	✗ No verification of understanding happens beyond obtaining a signature.
✓ The explanation covers specific facility characteristics and service limitations.	✗ Explanation, if given, is generic and doesn't reflect this facility's actual characteristics.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Explanation happens but is delivered quickly, at a moment when the family is visibly overwhelmed.**
Genuine understanding requires a moment that allows it, not just words spoken regardless of receptiveness.

2 **Verification happens for financial terms but not for service limitations or facility rules.**
Every major category of the agreement deserves the same genuine verification.

3 **A legal representative is present but the resident themselves, where capable, isn't included in the conversation.**
A resident capable of understanding deserves to be genuinely included, not spoken about in their absence.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current admission practice for genuine explanation versus document handover.

Week 2 Build a plain-language admission conversation guide covering all major agreement terms.

Week 3 Train admissions staff on teach-back verification technique.

Ongoing Spot-check family and resident understanding after admission.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a recent family member what they remember being told about facility-specific limitations.
This tests genuine understanding, not just that a document was signed.

Ask admissions staff to walk through their actual explanation process for a specific, recent admission.
A specific, confident answer reveals genuine practice, not a generic policy description.

E-LEARNING academy.gmj.ge/ltc-std1-1-admission-understanding — 30 min · complete before self-assessment

	Standard 1.2 **NON-NEGOTIABLE** · *Standard 1: Admission & Resident Rights* **Resident Rights Are Disclosed and Actively Explained**	**ASSESSMENT** ASF-LTC-STD1-v3.0

CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

1.2
NON-NEGOTIABLE
L1

THE STANDARD

Resident Rights Are Disclosed and Actively Explained

Every resident receives a genuine, understandable explanation of their rights — dignity, self-determination, communication and access to persons and services inside and outside the facility — not a rights document filed away unread after admission.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does every resident receive a genuine, understandable explanation of their rights, not just a document?** *A real explanation, not paperwork filed without discussion.* Doc: Rights explanation record	YES	PARTIAL	NO
2	**Can the resident, or their representative, describe at least one specific right in their own words?** *Tests genuine understanding, not just that disclosure technically occurred.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are rights actively protected in daily practice, not only disclosed once at admission?** *Genuine, ongoing protection, not a one-time formality.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Rights disclosure review*	Reviews documentation of rights explanation, not just a signed acknowledgment form.
ASK *Resident understanding interview*	Asks a resident or representative to describe a specific right in their own words.
OBSERVE *Daily practice observation*	Observes whether resident rights are genuinely respected in day-to-day facility practice.

REFERENCES

[2] The United Nations Principles for Older Persons (General Assembly resolution 46/91, 1991) establish that older persons residing in any care or treatment facility should enjoy full respect for their dignity, beliefs, needs, and privacy, and the right to make decisions about their care and the quality of their lives, requiring the facility to protect and promote these rights, not merely state them.

Standard 1.2 · *Standard 1: Admission & Resident Rights*

Guidance & Learning

GUIDANCE ASF-LTC-STD1-v3.0

WHY THIS STANDARD EXISTS

A resident's rights only function as real protection if the resident, or their representative, actually knows what they are — a rights notice buried in an admission packet provides no practical protection to someone who never reads it or doesn't understand what it means for their daily life.

The evidence: [2] The United Nations Principles for Older Persons (General Assembly resolution 46/91, 1991) establish that older persons residing in any care or treatment facility should enjoy full respect for their dignity, beliefs, needs, and privacy, and the right to make decisions about their care and the quality of their lives, requiring the facility to protect and promote these rights, not merely state them.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every resident receives a genuine, understandable rights explanation.	✗ Rights disclosure is a signed form with no real explanation.
✓ Residents or representatives can describe specific rights in their own words.	✗ Residents cannot describe any specific right when asked.
✓ Rights are actively protected in daily practice, not only disclosed once.	✗ Daily practice doesn't reflect genuine respect for disclosed rights.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Rights are explained at admission but never revisited as the resident's situation changes.**
A resident's capacity to exercise rights, and relevant circumstances, can genuinely change over a long stay.

2 **Explanation happens but isn't adapted for residents with cognitive impairment.**
A resident with cognitive impairment still has real rights, and disclosure needs genuine adaptation to reach them meaningfully.

3 **Rights are respected for most residents but inconsistently for those perceived as difficult or demanding.**
Rights apply equally regardless of how a resident's behavior is perceived by staff.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current rights disclosure practice for genuine explanation versus paperwork.

Week 2 Build an adapted explanation approach for residents with cognitive impairment.

Week 3 Train staff on recognising and respecting rights in daily practice, not only at admission.

Ongoing Revisit rights explanation periodically, particularly after a significant change in resident condition.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a resident directly what rights they remember being told about.
This tests genuine understanding, not disclosure compliance on paper.

Observe daily interactions for genuine respect of self-determination, not just formal rights disclosure.
This reveals whether rights are lived practice or a one-time administrative step.

E-LEARNING academy.gmj.ge/ltc-std1-2-resident-rights — 30 min · complete before self-assessment

	Standard 1.3 **NON-NEGOTIABLE** · *Standard 1: Admission & Resident Rights* **Financial Terms Are Transparent Before Admission Is Finalized**	**ASSESSMENT** ASF-LTC-STD1-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.3
NON-NEGOTIABLE
L1

THE STANDARD

Financial Terms Are Transparent Before Admission Is Finalized

Every charge, included and excluded service, and payment term is disclosed in writing before admission is finalized, with no requirement for a third-party payment guarantee as a condition of admission — not costs that emerge or change only after the resident has already moved in.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every charge and included or excluded service disclosed in writing before admission is finalized?** *Complete, written disclosure before the decision is finalized, not after.* Doc: Financial disclosure documentation	YES	PARTIAL	NO
2	**Is a third-party payment guarantee never required as a condition of admission?** *A firm, specific exclusion, not a judgement call made case by case.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are residents and families notified promptly of any change to covered services or charges during the stay?** *Genuine, timely notification, not costs that change silently.* Doc: Change notification record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Financial disclosure review*	Reviews written financial disclosure provided before admission for completeness.
ASK *Third-party guarantee policy interview*	Asks admissions staff directly whether a third-party payment guarantee is ever required.
DOCUMENT *Change notification review*	Reviews records of how residents are notified when covered services or charges change.

REFERENCES

[3] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit requiring a third-party guarantee of payment as a condition of admission, and require the facility to inform residents before or at admission of services available and their associated charges.

Standard 1.3 · *Standard 1: Admission & Resident Rights*

Guidance & Learning

GUIDANCE ASF-LTC-STD1-v3.0

WHY THIS STANDARD EXISTS

A family making an admission decision under real time pressure and emotional strain is in a poor position to negotiate or even notice unclear financial terms, and a facility that reveals costs only after admission has taken advantage of exactly that vulnerability, whether or not that was the intention.

The evidence: [3] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit requiring a third-party guarantee of payment as a condition of admission, and require the facility to inform residents before or at admission of services available and their associated charges.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Complete, written financial disclosure is provided before admission is finalized.	✗ Financial terms are incomplete or clarified only after admission.
✓ A third-party payment guarantee is never required as a condition of admission.	✗ A third-party guarantee is required or strongly implied as a condition of admission.
✓ Residents are promptly notified of any change to covered services or charges.	✗ Cost or coverage changes appear without prior notification.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Base charges are disclosed clearly but ancillary or optional service costs are less transparent.**
Ancillary costs can add up meaningfully and deserve the same transparency as base charges.

2 **Disclosure is complete at admission but not repeated when a resident's care needs, and therefore costs, change.**
Financial transparency matters throughout the stay, not only at its start.

3 **A third-party guarantee isn't formally required but is informally suggested during the admission conversation.**
An informal suggestion can carry the same coercive effect as a formal requirement.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current financial disclosure practice for completeness and timing.

Week 2 Build a complete, written financial disclosure document covering all charges and terms.

Week 3 Brief admissions staff that third-party guarantees are never required or suggested.

Ongoing Establish prompt notification practice for any change in covered services or charges.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual written financial disclosure given to a specific, recent resident.
A real, specific document reveals whether disclosure genuinely happens, not just exists as policy.

Ask directly whether a family member has ever been asked to personally guarantee payment.
A direct question often surfaces informal practice a policy review wouldn't catch.

E-LEARNING academy.gmj.ge/ltc-std1-3-financial-transparency — 30 min · complete before self-assessment

Standard 1.4 **NON-NEGOTIABLE** · *Standard 1: Admission & Resident Rights*

Transfer and Discharge Protections Are Real, Not Theoretical

ASSESSMENT ASF-LTC-STD1-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.4
NON-NEGOTIABLE
L1

THE STANDARD

Transfer and Discharge Protections Are Real, Not Theoretical

A resident is not transferred or discharged except for specific, defined, legally permitted reasons, with genuine advance notice and a real, participatory discharge plan — not moved out with inadequate warning or without a plan for where they will actually go.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does every transfer or discharge occur only for a specific, defined, legally permitted reason?** *A specific, documented reason, not a general judgement call.* Doc: Transfer/discharge reason documentation	YES	PARTIAL	NO
2	**Is genuine advance written notice given to the resident and their representative before transfer or discharge?** *Real, timely written notice, not informal or last-minute communication.* Doc: Advance notice record	YES	PARTIAL	NO
3	**Is the discharge plan genuinely developed with the resident and family, not handed to them as a completed decision?** *Genuine participation, not a plan presented as already finalized.* Doc: Discharge plan documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Transfer reason review*	Reviews documentation for a sample of transfers or discharges to confirm specific, permitted reasons.
DOCUMENT *Advance notice review*	Reviews records for genuine, timely written notice before transfer or discharge.
ASK *Family participation interview*	Asks a family member whether they genuinely participated in developing a discharge plan.

REFERENCES

[4] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, permit transfer or discharge only for specific defined reasons, require advance written notice, and require a participatory discharge plan developed with the resident and family.

Standard 1.4 · *Standard 1: Admission & Resident Rights*

Guidance & Learning

GUIDANCE ASF-LTC-STD1-v3.0

WHY THIS STANDARD EXISTS

Involuntary transfer or discharge from a long-term care facility can be genuinely destabilising and, in the worst cases, dangerous for a resident who depends entirely on this facility for daily care — the protections around this exist specifically because the resident has far less power in this relationship than the facility does.

The evidence: [4] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, permit transfer or discharge only for specific defined reasons, require advance written notice, and require a participatory discharge plan developed with the resident and family.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every transfer or discharge occurs for a specific, documented, permitted reason.	✗ Transfers or discharges happen without a specific, documented, permitted reason.
✓ Genuine advance written notice is given before transfer or discharge.	✗ Notice is informal, late, or absent.
✓ Discharge plans are genuinely developed with resident and family participation.	✗ Discharge plans are presented as already-finalized decisions.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Advance notice is given but doesn't specify the resident's right to appeal the decision.**
Genuine notice includes the resident's actual rights in response, not only the decision itself.

2 **Discharge planning involves the family but not the resident directly, even where the resident is capable of participating.**
A capable resident deserves genuine inclusion in decisions about their own discharge.

3 **The reason given is technically permitted but documentation doesn't clearly establish it applies to this specific case.**
A permitted category of reason still requires genuine, specific justification for this particular resident.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent transfers and discharges for documented, permitted reasons and genuine advance notice.

Week 2 Establish a standard advance notice process including appeal rights information.

Week 3 Build a genuinely participatory discharge planning process involving resident and family.

Ongoing Audit transfer and discharge documentation for continued compliance.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual documentation behind a real, recent transfer or discharge.
A specific, real case reveals whether the process genuinely functions, not just exists as policy.

Ask a family member whether they felt genuinely included in discharge planning, not just informed of a decision.
This reveals whether participation is real or nominal.

E-LEARNING academy.gmj.ge/ltc-std1-4-transfer-discharge-protection — 30 min · complete before self-assessment

	Standard 1.5 **CORE** · *Standard 1: Admission & Resident Rights* **Grievances Are Genuinely Heard and Resolved**	**ASSESSMENT** ASF-LTC-STD1-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.5
CORE
L1

THE STANDARD

Grievances Are Genuinely Heard and Resolved

Residents and families can voice a grievance through a genuine, accessible process, free from any retaliation, with real evidence that grievances lead to a documented response and, where warranted, an actual change — not a suggestion box that generates no real action.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a genuine, accessible process for residents and families to voice a grievance?** *A real, known process, not a theoretical right with no practical channel.* Doc: Grievance process documentation	YES	PARTIAL	NO
2	**Is there real, documented evidence that grievances lead to a response and, where warranted, an actual change?** *Genuine follow-through, not a process that receives complaints without acting on them.* Doc: Grievance resolution record	YES	PARTIAL	NO
3	**Are residents and families confident that raising a grievance carries no risk of retaliation?** *Genuine confidence, not just a stated non-retaliation policy.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Grievance process review*	Reviews the actual, accessible grievance process available to residents and families.
DOCUMENT *Resolution record review*	Reviews documented evidence of grievance response and resulting action where warranted.
ASK *Retaliation confidence interview*	Asks residents or family members whether they would feel safe raising a concern.

REFERENCES

[5] The United Nations Principles for Older Persons establish that older persons should be able to live in dignity and security, free of exploitation and abuse, a principle reflected in established long-term care practice as the resident's right to voice grievances without retaliation and prompt facility efforts to resolve them.

Standard 1.5 · *Standard 1: Admission & Resident Rights*

Guidance & Learning

GUIDANCE ASF-LTC-STD1-v3.0

WHY THIS STANDARD EXISTS

A resident's or family's willingness to raise a concern depends entirely on believing it will actually be heard without consequence, and a facility where grievances quietly go nowhere teaches everyone, over time, that raising a concern isn't worth the risk — which means real problems go unreported until they become serious.

The evidence: [5] The United Nations Principles for Older Persons establish that older persons should be able to live in dignity and security, free of exploitation and abuse, a principle reflected in established long-term care practice as the resident's right to voice grievances without retaliation and prompt facility efforts to resolve them.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine, accessible grievance process is known and used.	✗ No accessible grievance process exists, or it's unknown to residents and families.
✓ Real, documented evidence shows grievances lead to response and action.	✗ Grievances are received but produce no documented response or action.
✓ Residents and families express genuine confidence about raising concerns without retaliation.	✗ Residents or families express fear of retaliation for raising concerns.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **A grievance process exists but residents with cognitive impairment have no adapted way to use it.**
Every resident, regardless of cognitive capacity, deserves a genuine way to have concerns heard.

2 **Grievances receive a response but resolution isn't tracked to confirm the underlying issue was actually addressed.**
A response isn't the same as genuine resolution of the concern raised.

3 **Families feel comfortable raising concerns but residents themselves are less confident doing so directly.**
A resident's own voice matters as much as their family's, and both deserve genuine confidence in the process.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current grievance process for genuine accessibility and follow-through.

Week 2 Build an adapted grievance channel for residents with cognitive impairment.

Week 3 Establish tracked resolution confirming grievances lead to genuine action.

Ongoing Monitor grievance patterns and resident/family confidence in the process.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent example of a grievance and what actually happened as a result.
A real example reveals whether the process genuinely functions, not just exists on paper.

Ask a resident directly whether they'd feel safe raising a complaint.
A confident, genuine answer is the clearest evidence of real, retaliation-free practice.

E-LEARNING academy.gmj.ge/ltc-std1-5-grievance-resolution — 30 min · complete before self-assessment

STANDARD 2

Living Environment & Safety

MANDATORY

5 criteria

	Standard 2.1 NON-NEGOTIABLE · *Standard 2: Living Environment & Safety* **Falls Prevention Is Individualized, Not Generic**	ASSESSMENT ASF-LTC-STD2-v3.0
CR ADAPTED	TR FULL	SM FULL / ST FULL

2.1
NON-NEGOTIABLE
L1

THE STANDARD

Falls Prevention Is Individualized, Not Generic

Every resident undergoes a specific falls risk assessment at admission and after any significant change, with an individualized care plan addressing that resident's actual identified risk factors — not a generic facility-wide falls policy applied identically regardless of individual risk.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does every resident undergo a specific falls risk assessment at admission and after any significant change?** *A specific, individual assessment, not a general facility-wide falls policy alone.* Doc: Falls risk assessment record	YES	PARTIAL	NO
2	**Does the resulting care plan address this specific resident's actual identified risk factors?** *Individualized interventions matched to this resident's real risk factors, not generic falls precautions.* Doc: Individualized falls care plan	YES	PARTIAL	NO
3	**Is the falls risk assessment genuinely updated after a significant change in condition, not only at admission?** *A living assessment, not a one-time evaluation that goes stale as the resident's condition changes.* Doc: Reassessment record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Falls risk assessment review*	Reviews falls risk assessments for a sample of residents for specificity and individual relevance.
DOCUMENT *Care plan individualization review*	Reviews whether care plans reflect this specific resident's identified risk factors, not generic precautions.
ASK *Reassessment trigger interview*	Asks staff what specifically triggers a falls risk reassessment beyond the admission evaluation.

REFERENCES

[6] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to ensure the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision, assistance, and devices to prevent accidents, including falls.

Standard 2.1 · *Standard 2: Living Environment & Safety*

Guidance & Learning

GUIDANCE ASF-LTC-STD2-v3.0

WHY THIS STANDARD EXISTS

Falls are a leading cause of injury and death for long-term care residents, and the risk factors driving a specific resident's fall risk — medication interactions, mobility limitations, cognitive status — genuinely differ from resident to resident. A facility-wide policy that doesn't reflect this individual reality misses the specific risks most likely to actually cause harm.

The evidence: [6] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to ensure the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision, assistance, and devices to prevent accidents, including falls.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every resident has a specific, individual falls risk assessment.	✗ Falls prevention relies on a generic, facility-wide policy with no individual assessment.
✓ Care plans address this specific resident's actual identified risk factors.	✗ Care plans list generic falls precautions unrelated to the resident's actual risk factors.
✓ Reassessment genuinely happens after significant condition changes.	✗ Assessment happens only once at admission, never updated.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Assessment happens at admission but reassessment after a fall or condition change is inconsistent.**
A resident's risk can change significantly, and reassessment needs to reliably follow those changes.

2 **Risk factors are identified but the care plan doesn't specifically address each one individually.**
Identifying a risk factor without a specific, matched intervention doesn't reduce the actual risk.

3 **Assessment is thorough for physical risk factors but doesn't consider medication-related fall risk.**
Medication effects are a well-documented, significant, and modifiable falls risk factor.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current falls risk assessment practice for genuine individualization.

Week 2 Establish a structured reassessment trigger tied to significant condition changes.

Week 3 Ensure care plans specifically address each resident's own identified risk factors.

Ongoing Audit falls incidents against risk assessments to confirm plans are genuinely followed.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see a specific resident's falls risk assessment and compare it against their actual care plan.
A real, matched example reveals whether individualization is genuine practice, not just policy language.

Ask what happens to the falls plan after a resident's medication changes.
This reveals whether reassessment genuinely accounts for modifiable, medication-related risk.

E-LEARNING academy.gmj.ge/ltc-std2-1-falls-prevention — 30 min · complete before self-assessment

	Standard 2.2 NON-NEGOTIABLE · *Standard 2: Living Environment & Safety* **Physical Restraints Are the Last Resort, Not the Default Response**	ASSESSMENT ASF-LTC-STD2-v3.0
CR ADAPTED	TR FULL	SM FULL / ST FULL

2.2
NON-NEGOTIABLE
L1

THE STANDARD

Physical Restraints Are the Last Resort, Not the Default Response

Physical or chemical restraints are never used for staff convenience or resident discipline, only when genuinely required to treat a documented medical symptom, with the least restrictive alternative tried and documented first — not applied as a default response to a resident who is difficult to manage.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are physical or chemical restraints ever used for staff convenience or resident discipline?** *A firm, specific exclusion — this should never happen, not a judgement call made case by case.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**When restraint use is genuinely medically indicated, is it tied to a documented medical symptom, not general behavior management?** *A specific, documented medical justification, not a vague behavioral rationale.* Doc: Restraint justification documentation	YES	PARTIAL	NO
3	**Is the least restrictive alternative genuinely tried and documented before restraint use, not skipped as a formality?** *Real, documented attempts at less restrictive options first, not a box checked after the fact.* Doc: Least restrictive alternative documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Restraint use record review*	Reviews restraint use records for documented medical justification, not convenience or discipline.
DOCUMENT *Least restrictive alternative review*	Reviews documentation of less restrictive alternatives genuinely tried before restraint use.
ASK *Staff practice interview*	Asks staff directly how they'd handle a resident who is difficult to manage, without restraints.

REFERENCES

[7] The United Nations Principles for Older Persons establish the right of older persons to live in dignity and be free of exploitation and physical or mental abuse, a principle reflected in established long-term care practice as the resident's right to be free from physical or chemical restraints imposed for discipline or convenience, requiring the least restrictive alternative when restraint use is genuinely indicated.

Standard 2.2 · *Standard 2: Living Environment & Safety*

Guidance & Learning

GUIDANCE ASF-LTC-STD2-v3.0

WHY THIS STANDARD EXISTS

Restraint use for convenience rather than genuine medical necessity is a well-documented, serious violation of resident dignity and autonomy, and history in long-term care specifically shows this can happen gradually, normalized as routine practice, unless there's a genuine, active requirement to try less restrictive alternatives first and document why they weren't sufficient.

The evidence: [7] The United Nations Principles for Older Persons establish the right of older persons to live in dignity and be free of exploitation and physical or mental abuse, a principle reflected in established long-term care practice as the resident's right to be free from physical or chemical restraints imposed for discipline or convenience, requiring the least restrictive alternative when restraint use is genuinely indicated.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Restraints are never used for convenience or discipline.	✗ Restraints are used to manage a resident who is difficult or time-consuming to supervise.
✓ Restraint use, when it occurs, is tied to a specific, documented medical symptom.	✗ Restraint justification is vague or behavioral rather than medically specific.
✓ Less restrictive alternatives are genuinely tried and documented first.	✗ Less restrictive alternatives are not genuinely attempted before restraint use.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Medical justification is documented but the specific symptom being treated isn't always clearly identified.**
A vague justification is difficult to distinguish from convenience-driven restraint use after the fact.

2 **Less restrictive alternatives are considered for new restraint orders but not reconsidered for long-standing ones.**
A resident's need for a restraint can change over time, and ongoing use deserves the same scrutiny as initial use.

3 **Staff understand the policy but describe genuine uncertainty about practical alternatives in difficult moments.**
A policy without practical, real alternatives staff can actually use tends to erode under real pressure.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current restraint use for documented medical justification versus convenience.

Week 2 Train staff on practical, less restrictive alternatives to restraint use.

Week 3 Establish a documented process requiring alternatives be tried and recorded first.

Ongoing Review all restraint use, including long-standing orders, on a regular schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the specific documented medical symptom behind a real, current restraint use.
A specific, real answer reveals genuine medical justification versus convenience.

Ask staff what they would do instead of restraint for a specific, difficult scenario.
A confident, specific answer reveals whether alternatives are genuinely practiced, not just known in theory.

E-LEARNING academy.gmj.ge/ltc-std2-2-restraint-free-care — 30 min · complete before self-assessment

	Standard 2.3 **NON-NEGOTIABLE** · *Standard 2: Living Environment & Safety* **The Resident Call System Reaches Staff Immediately, Every Time**	**ASSESSMENT** ASF-LTC-STD2-v3.0

CR ADAPTED	**TR** FULL	**SM** FULL	**ST** FULL

2.3
NON-NEGOTIABLE
L1

THE STANDARD

The Resident Call System Reaches Staff Immediately, Every Time

Every resident can summon staff assistance through a call system that reaches a staff member or centralized work area immediately, from their bed, bathroom, and any common area — verified as actually working, not assumed functional because it exists.

FACILITY SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Can every resident summon staff assistance from their bed, bathroom, and common areas?** *Coverage in every location a resident might genuinely need to call for help, not just the bedroom.* Doc: Call system coverage documentation	YES	PARTIAL	NO
2	**Is the call system verified as actually functioning, not assumed working because it's installed?** *Genuine, tested verification, not an assumption based on installation alone.* Doc: Call system function testing record	YES	PARTIAL	NO
3	**Does a call genuinely reach a staff member promptly, not go unanswered or significantly delayed?** *Real, prompt response, not a system that technically rings without reliable staff response.* Doc: Response time record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

OBSERVE *Call system coverage check*	Physically checks call system presence and function in bedrooms, bathrooms, and common areas.
DOCUMENT *Function testing record review*	Reviews records of regular call system testing and maintenance.
OBSERVE *Response time observation*	Tests an actual call and observes genuine staff response time.

REFERENCES

[8] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to be adequately equipped with a resident call system that relays the call directly to a staff member or centralized staff work area.

Standard 2.3 · *Standard 2: Living Environment & Safety*

Guidance & Learning

GUIDANCE ASF-LTC-STD2-v3.0

WHY THIS STANDARD EXISTS

A resident's ability to call for help when something goes wrong — a fall, sudden illness, distress — depends entirely on a call system that genuinely, reliably reaches staff, and a system that exists but doesn't actually work provides false reassurance that's arguably worse than no system at all.

The evidence: [8] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to be adequately equipped with a resident call system that relays the call directly to a staff member or centralized staff work area.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every resident location has a genuinely functioning call system.	✗ Call system coverage has gaps in bathrooms or common areas.
✓ The system is regularly tested and verified, not assumed working.	✗ No regular testing verifies the system actually functions.
✓ Calls reach staff promptly with genuine response.	✗ Calls go unanswered or are significantly delayed.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Bedroom call systems are reliable but bathroom coverage is inconsistent.**
Bathrooms are a common location for falls and medical emergencies, and coverage there matters as much as bedrooms.

2 **The system is tested periodically but response time isn't specifically measured.**
A functioning call system without prompt response doesn't provide the real protection this criterion exists to ensure.

3 **Response is prompt during day shifts but slower overnight.**
A resident's need for help doesn't diminish overnight, and staffing patterns shouldn't create a real gap in response.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Physically verify call system coverage and function across all resident areas.

Week 2 Establish a regular testing schedule for call system function.

Week 3 Measure and address response time, including overnight coverage.

Ongoing Test call system function and response time on a recurring schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Test an actual call from a bathroom, not just a bedroom.
This is where coverage gaps most commonly exist.

Time the actual response to a test call, including during an overnight visit if possible.
Direct observation is the only real evidence of genuine, prompt response, not just system installation.

E-LEARNING academy.gmj.ge/ltc-std2-3-resident-call-system — 30 min · complete before self-assessment

Standard 2.4 **NON-NEGOTIABLE** · *Standard 2: Living Environment & Safety*

Fire Safety Follows a Recognized Life Safety Standard

ASSESSMENT ASF-LTC-STD2-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

2.4
NON-NEGOTIABLE
L1

THE STANDARD

Fire Safety Follows a Recognized Life Safety Standard

The facility's fire safety systems and practices — construction, egress, fire-rated doors, staff drills — follow a recognized life safety code appropriate to a residential care setting, verified through regular, genuine drills, not assumed compliant because the building passed an initial inspection.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the facility's construction and fire safety equipment follow an applicable, recognized life safety standard?** *Specific, verified compliance with the applicable standard, not general fire safety awareness.* Doc: Life safety standard compliance documentation	YES	PARTIAL	NO
2	**Are fire drills genuinely conducted on a regular schedule, accounting for residents' actual mobility and cognitive needs?** *Real, practiced drills reflecting the actual resident population, not a generic evacuation drill.* Doc: Fire drill record	YES	PARTIAL	NO
3	**Are corridor doors and doors to rooms with flammable materials equipped with proper fire-rated latching hardware?** *Specific, verified hardware compliance, not assumed from the building's age or general condition.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Life safety standard compliance review*	Reviews documentation of compliance with the applicable, recognized life safety standard.
DOCUMENT *Fire drill record review*	Reviews fire drill records for regular scheduling and realistic accounting for resident mobility needs.
OBSERVE *Fire door hardware check*	Physically checks corridor and flammable-material room doors for proper fire-rated hardware.

REFERENCES

[9] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to meet an applicable, recognized fire and life safety standard, including fire-rated corridor doors with positive latching hardware.

Standard 2.4 · *Standard 2: Living Environment & Safety*

Guidance & Learning

GUIDANCE ASF-LTC-STD2-v3.0

WHY THIS STANDARD EXISTS

Evacuating a building full of residents with mobility limitations and cognitive impairment during a fire is genuinely difficult in ways an evacuation of mobile, independent adults isn't, and a life safety standard specifically designed for this kind of population exists precisely because generic building fire codes don't adequately address it.

The evidence: [9] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to meet an applicable, recognized fire and life safety standard, including fire-rated corridor doors with positive latching hardware.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Construction and equipment genuinely comply with an applicable, recognized life safety standard.	✗ Compliance with the applicable life safety standard is assumed rather than verified.
✓ Fire drills are regularly conducted and realistically account for resident mobility and cognitive needs.	✗ Fire drills are infrequent or don't reflect the actual resident population's real evacuation needs.
✓ Fire-rated door hardware is verified present and functioning.	✗ Door hardware doesn't meet fire-rating requirements.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 Drills happen regularly but don't specifically practice evacuating residents with significant mobility limitations.
A drill that doesn't reflect real evacuation challenges provides limited genuine preparation.

2 Fire door hardware is compliant in most areas but not consistently verified throughout the building.
A single non-compliant door can undermine the fire safety the rest of the building's compliance is meant to provide.

3 Life safety standard compliance was verified at construction but not reconfirmed as the building ages.
Fire safety systems can degrade over time and benefit from periodic reverification, not only initial certification.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current life safety standard compliance documentation and verify current status.

Week 2 Establish or strengthen a fire drill schedule realistically accounting for resident mobility and cognitive needs.

Week 3 Physically verify fire-rated door hardware throughout the facility.

Ongoing Conduct drills on a recurring schedule and periodically reverify life safety standard compliance.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to observe or review documentation from an actual, recent fire drill.
A real, specific drill record reveals whether practice is genuine, not just policy on paper.

Physically check a sample of corridor doors for proper fire-rated latching hardware.
Direct physical verification is the only real evidence of genuine compliance.

E-LEARNING academy.gmj.ge/ltc-std2-4-fire-safety — 30 min · complete before self-assessment

Standard 2.5 **CORE** · *Standard 2: Living Environment & Safety*

Bathroom and Room Configuration Genuinely Support Dignity and Independence

ASSESSMENT ASF-LTC-STD2-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

2.5
CORE
L1

THE STANDARD

Bathroom and Room Configuration Genuinely Support Dignity and Independence

Resident rooms and bathroom facilities are configured to genuinely support privacy, dignity, and the greatest possible independence — private or accessible bathroom facilities, adequate space, personal storage — not merely meeting a minimum institutional standard.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does every resident have private or genuinely accessible bathroom facilities meeting the applicable standard?** *Genuine accessibility and privacy, not a distant or shared facility that functions poorly in practice.* Doc: Bathroom facility documentation	YES	PARTIAL	NO
2	**Does room configuration provide adequate space and personal storage for the resident's own belongings?** *Real, adequate space, not a minimal institutional footprint.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Do residents have genuine privacy in their own room, not routinely compromised by staff or facility practice?** *Real, respected privacy, not privacy that exists on paper but is routinely overridden in practice.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Bathroom facility check*	Physically verifies bathroom facility accessibility and privacy for resident rooms.
OBSERVE *Room configuration check*	Assesses room space and personal storage adequacy directly.
ASK *Privacy practice interview*	Asks residents whether their privacy is genuinely respected in daily practice.

REFERENCES

[10] The United Nations Principles for Older Persons establish that older persons should be able to live in environments that are safe and adaptable to personal preferences, a principle reflected in established long-term care practice as requiring each resident room to be equipped with or located near toilet and bathing facilities supporting genuine dignity and independence.

Standard 2.5 · *Standard 2: Living Environment & Safety*

Guidance & Learning

GUIDANCE ASF-LTC-STD2-v3.0

WHY THIS STANDARD EXISTS

Where and how a resident lives, for what is often the remainder of their life, shapes their daily dignity and sense of self in a way that goes beyond basic physical safety — a room and bathroom configuration that meets only bare institutional minimums treats housing as an afterthought to care, when for a long-term resident it is genuinely part of the care itself.

The evidence: [10] The United Nations Principles for Older Persons establish that older persons should be able to live in environments that are safe and adaptable to personal preferences, a principle reflected in established long-term care practice as requiring each resident room to be equipped with or located near toilet and bathing facilities supporting genuine dignity and independence.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Bathroom facilities are genuinely private and accessible for every resident.	✗ Bathroom facilities are distant, shared in ways that compromise privacy, or difficult to access.
✓ Room configuration provides adequate space and personal storage.	✗ Room space and storage are minimal, institutional, and inadequate.
✓ Residents report genuine, respected privacy in daily practice.	✗ Privacy is routinely compromised by staff or facility practice.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Bathroom facilities meet minimum requirements but aren't genuinely convenient for residents with mobility limitations.**
Technical compliance doesn't guarantee genuine day-to-day accessibility for the actual resident population.

2 **Personal storage exists but is too limited for residents to keep meaningful personal belongings.**
Personal belongings often carry real emotional significance for long-term residents, beyond mere storage capacity.

3 **Privacy is respected by most staff but inconsistently by some, particularly during personal care.**
Consistent respect for privacy across all staff and all interactions is what makes it genuinely reliable for residents.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current bathroom and room configuration against genuine dignity and accessibility standards.

Week 2 Address any gaps in bathroom accessibility or personal storage adequacy.

Week 3 Train staff specifically on consistent privacy practice, particularly during personal care.

Ongoing Gather resident feedback on genuine privacy and dignity in daily living.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a resident directly whether their privacy is genuinely respected, not just technically provided.
This tests lived experience, not facility design alone.

Observe an actual room and bathroom configuration directly, not just review facility specifications.
Direct observation reveals genuine day-to-day functionality, not just compliance on paper.

E-LEARNING academy.gmj.ge/ltc-std2-5-room-dignity — 30 min · complete before self-assessment

STANDARD 3

Personal Care & Daily Living

MANDATORY

5 criteria

	Standard 3.1 **NON-NEGOTIABLE** · *Standard 3: Personal Care & Daily Living* **Activities of Daily Living Support Prevents Unnecessary Decline**	**ASSESSMENT** ASF-LTC-STD3-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.1
NON-NEGOTIABLE
L1

THE STANDARD

Activities of Daily Living Support Prevents Unnecessary Decline

A resident's ability to perform activities of daily living — hygiene, mobility, eating, toileting — is actively supported to prevent avoidable decline, with any diminution genuinely tied to an unavoidable clinical cause, documented specifically, not assumed as a normal part of aging or long-term residence.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is ADL support genuinely aimed at maintaining the resident's own ability, not simply completing the task for them?** *Support that maintains capability, not task completion that bypasses it.* Doc: ADL care plan and approach documentation	YES	PARTIAL	NO
2	**When ADL decline occurs, is it specifically tied to a documented, unavoidable clinical cause?** *A specific, documented clinical reason, not an assumption that decline is simply expected.* Doc: Decline documentation and clinical justification	YES	PARTIAL	NO
3	**Are care plans reviewed and adjusted as a resident's ADL ability changes, in either direction?** *Genuine, ongoing adjustment, not a static plan set once and left unchanged.* Doc: ADL care plan review record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *ADL support practice observation*	Observes actual ADL assistance for genuine ability-maintaining support versus task completion.
DOCUMENT *Decline documentation review*	Reviews documented ADL decline for specific, genuine clinical justification.
DOCUMENT *Care plan review record check*	Reviews whether ADL care plans are genuinely reviewed and adjusted as ability changes.

REFERENCES

[11] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to provide necessary care and services to ensure a resident's abilities in activities of daily living do not diminish unless the individual's clinical condition demonstrates the diminution was unavoidable.

Standard 3.1 · *Standard 3: Personal Care & Daily Living*

Guidance & Learning

GUIDANCE ASF-LTC-STD3-v3.0

WHY THIS STANDARD EXISTS

A resident who loses functional ability because staff did tasks for them rather than supporting them to do it themselves has experienced a genuinely preventable decline — the difference between assisting a resident to maintain their own ability and simply doing the task faster without them is exactly the difference this criterion exists to protect.

The evidence: [11] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to provide necessary care and services to ensure a resident's abilities in activities of daily living do not diminish unless the individual's clinical condition demonstrates the diminution was unavoidable.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ ADL support genuinely maintains resident capability, not just completes tasks.	✗ Staff routinely complete ADL tasks for residents who could do them with support.
✓ Any decline is tied to a specific, documented, unavoidable clinical cause.	✗ Decline is assumed as normal aging without specific clinical justification.
✓ Care plans are genuinely reviewed and adjusted as ability changes.	✗ Care plans remain static despite genuine changes in resident ability.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Ability-maintaining support happens during less busy periods but tasks are completed directly when time is short.**
Genuine support needs to hold up under real time pressure, not only when convenient.

2 **Decline is documented but the specific clinical cause isn't always clearly identified.**
A vague justification is difficult to distinguish from decline that was actually preventable.

3 **Care plans are reviewed on schedule but don't consistently reflect genuine changes in resident ability.**
A scheduled review that doesn't produce real adjustment doesn't provide the ongoing responsiveness this requires.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current ADL support practice for genuine ability-maintaining approach.

Week 2 Train staff specifically on supporting rather than replacing resident capability.

Week 3 Establish specific clinical documentation requirements for any ADL decline.

Ongoing Review and adjust ADL care plans as resident ability genuinely changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual ADL assistance interaction, particularly during a busy period.
This is where the real difference between support and task completion is most visible.

Ask for a specific example of documented decline and its clinical justification.
A real, specific example reveals whether justification is genuine, not just assumed.

E-LEARNING academy.gmj.ge/ltc-std3-1-adl-support — 30 min · complete before self-assessment

Standard 3.2 **NON-NEGOTIABLE** · *Standard 3: Personal Care & Daily Living*

Nutrition and Hydration Are Individualized and Actively Monitored

ASSESSMENT ASF-LTC-STD3-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.2
NON-NEGOTIABLE
L1

THE STANDARD

Nutrition and Hydration Are Individualized and Actively Monitored

Every resident receives a nourishing diet meeting their individual nutritional and special dietary needs, with hydration and eating assistance actively provided as needed — not a standardized menu applied uniformly regardless of individual requirements.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does every resident's diet reflect their individual nutritional and special dietary needs, not a uniform standard menu?** *Genuine individualization, not a single menu applied regardless of individual requirements.* Doc: Individual nutrition plan documentation	YES	PARTIAL	NO
2	**Is assistance with eating and drinking actively provided to residents who need it, not left for the resident to manage alone?** *Real, active assistance, not passive availability of food and drink alone.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is a qualified dietitian or nutrition professional genuinely involved in developing individual nutrition plans?** *Genuine professional involvement, not a generic plan without individual clinical input.* Doc: Dietitian involvement record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Individual nutrition plan review*	Reviews nutrition plans for a sample of residents for genuine individualization.
OBSERVE *Eating and drinking assistance observation*	Observes an actual mealtime for genuine, active assistance to residents who need it.
DOCUMENT *Dietitian involvement review*	Reviews evidence of genuine dietitian or nutrition professional involvement in individual plans.

REFERENCES

[12] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to provide each resident a nourishing, palatable, well-balanced diet meeting individual nutritional and special dietary needs, with assistance provided as needed.

Standard 3.2 · *Standard 3: Personal Care & Daily Living*

Guidance & Learning

GUIDANCE ASF-LTC-STD3-v3.0

WHY THIS STANDARD EXISTS

Malnutrition and dehydration are genuinely serious, well-documented risks in long-term care specifically, and a resident who needs assistance eating or drinking, or who has specific dietary requirements, faces real harm if a standardized approach doesn't account for their actual individual needs.

The evidence: [12] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to provide each resident a nourishing, palatable, well-balanced diet meeting individual nutritional and special dietary needs, with assistance provided as needed.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every resident's diet genuinely reflects their individual needs.	✗ A standardized menu is applied regardless of individual dietary needs.
✓ Eating and drinking assistance is actively provided to residents who need it.	✗ Residents needing assistance are left to manage eating or drinking alone.
✓ A qualified dietitian is genuinely involved in individual nutrition planning.	✗ Nutrition plans lack genuine professional dietitian involvement.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Special dietary needs are accommodated for major conditions but not consistently for less common ones.**
Every documented dietary need carries real risk if genuinely unaddressed, not only the most common ones.

2 **Assistance is provided but rushed during busy mealtime periods.**
Rushed assistance can result in inadequate intake even when technically provided.

3 **Dietitian involvement happens at initial assessment but isn't revisited as a resident's condition changes.**
Nutritional needs can change meaningfully over a long-term stay, and planning needs to reflect that.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current nutrition planning for genuine individualization versus standardized menus.

Week 2 Strengthen dietitian involvement in individual nutrition plan development.

Week 3 Observe and address mealtime assistance practice, particularly during busy periods.

Ongoing Revisit nutrition plans as resident condition changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual mealtime, particularly for residents who need eating assistance.
Direct observation reveals whether assistance is genuine and adequate, not rushed or assumed.

Ask how a specific resident's special dietary need is actually accommodated in practice.
A specific, real answer reveals genuine individualization, not policy language alone.

E-LEARNING academy.gmj.ge/ltc-std3-2-nutrition-hydration — 30 min · complete before self-assessment

Standard 3.3 **NON-NEGOTIABLE** · *Standard 3: Personal Care & Daily Living*

Weight Loss Is Caught Early, Using a Specific Threshold

ASSESSMENT ASF-LTC-STD3-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.3
NON-NEGOTIABLE
L1

THE STANDARD

Weight Loss Is Caught Early, Using a Specific Threshold

Resident weight is monitored on a defined schedule, with a specific, recognised threshold for significant weight loss triggering immediate clinical review — not weight changes noticed informally or only after they become visually apparent.

FACILITY SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Is resident weight monitored on a defined, regular schedule, not informally or irregularly?** *A specific, scheduled monitoring interval, not ad hoc weighing.* Doc: Weight monitoring schedule and record	YES	PARTIAL	NO
2	**Does the specific 5% in 30 days or 10% in 180 days threshold trigger immediate clinical review?** *A specific, recognised threshold, not a vague sense that weight loss seems concerning.* Doc: Significant weight loss response record	YES	PARTIAL	NO
3	**Once significant weight loss is identified, does monitoring frequency genuinely increase?** *Real, increased monitoring, not the same schedule continued regardless.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Monitoring schedule review*	Reviews the weight monitoring schedule and actual adherence to it.
DOCUMENT *Threshold response review*	Reviews records for genuine, immediate clinical review when the significant weight loss threshold is met.
DOCUMENT *Increased monitoring review*	Reviews whether monitoring frequency genuinely increases after significant weight loss is identified.

REFERENCES

[13] Established long-term care clinical practice recognizes significant unintended weight loss — commonly defined as approximately 5 percent in 30 days or 10 percent in 180 days — as a threshold requiring active identification, response, and increased monitoring frequency once loss is identified.

Standard 3.3 · *Standard 3: Personal Care & Daily Living*

Guidance & Learning

GUIDANCE ASF-LTC-STD3-v3.0

WHY THIS STANDARD EXISTS

Significant, unintended weight loss is a genuinely serious warning sign in long-term care, often reflecting an underlying problem that hasn't yet been identified any other way, and catching it early through defined, scheduled monitoring against a specific threshold is measurably more reliable than waiting for it to become visually obvious.

The evidence: [13] Established long-term care clinical practice recognizes significant unintended weight loss — commonly defined as approximately 5 percent in 30 days or 10 percent in 180 days — as a threshold requiring active identification, response, and increased monitoring frequency once loss is identified.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Weight is monitored on a defined, consistently followed schedule.	✗ Weight monitoring is irregular or informal.
✓ The specific threshold reliably triggers immediate clinical review.	✗ The threshold, even when met, doesn't reliably trigger review.
✓ Monitoring frequency genuinely increases once significant loss is identified.	✗ Monitoring frequency doesn't change after significant weight loss is identified.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Monthly weighing happens consistently but the specific percentage calculation isn't always performed.**
Recording weight without calculating against the specific threshold misses the actual early-warning value.

2 **Clinical review happens for weight loss but not consistently within a genuinely prompt timeframe.**
The protective value of early identification depends on genuinely prompt follow-up, not eventual review.

3 **Increased monitoring is ordered but not consistently followed through in practice.**
An ordered change that isn't genuinely implemented doesn't provide real additional protection.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current weight monitoring schedule and threshold calculation practice.

Week 2 Establish consistent, systematic threshold calculation against the specific benchmark.

Week 3 Establish a defined, prompt clinical review process triggered by the threshold.

Ongoing Audit monitoring frequency increases following identified significant weight loss.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a specific, real example of significant weight loss and the resulting clinical response.
A real example reveals whether the threshold genuinely triggers action, not just gets recorded.

Check whether the specific percentage calculation is actually performed, not just weight recorded.
This is the precise mechanism that makes early identification possible.

E-LEARNING academy.gmj.ge/ltc-std3-3-weight-loss-monitoring — 30 min · complete before self-assessment

Standard 3.4 **CORE** · *Standard 3: Personal Care & Daily Living*

Food and Activities Reflect Genuine Cultural and Personal Preference

ASSESSMENT ASF-LTC-STD3-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

3.4
CORE
L1

THE STANDARD

Food and Activities Reflect Genuine Cultural and Personal Preference

Food and activities genuinely reflect each resident's cultural, religious, and personal preferences — with documented, active effort to learn these preferences even from a resident with dementia or communication barriers, not a standardized program applied uniformly regardless of individual background.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Do food and activities genuinely reflect individual residents' cultural, religious, and personal preferences?** *Genuine, individual reflection, not a standardized program applied uniformly.* Doc: Preference accommodation documentation	YES	PARTIAL	NO
2	**For residents with dementia or communication barriers, is there documented, active effort to learn their preferences?** *Specific, documented effort, not an assumption that preferences can't be learned.* Doc: Preference-learning documentation for residents with communication barriers	YES	PARTIAL	NO
3	**Are learned preferences actually reflected in what's provided, not just recorded without follow-through?** *Genuine follow-through, not preferences noted but not actually acted on.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Preference accommodation review*	Reviews evidence that food and activities genuinely reflect individual resident preferences.
DOCUMENT *Communication barrier effort review*	Reviews documented effort to learn preferences from residents with dementia or communication barriers.
OBSERVE *Follow-through observation*	Checks whether documented preferences are genuinely reflected in what's actually provided.

REFERENCES

[14] The United Nations Principles for Older Persons establish that older persons should be able to live in environments adaptable to personal preferences, a principle reflected in established long-term care practice as the facility's responsibility to make reasonable efforts to learn and accommodate each resident's cultural and personal food preferences, including documented steps to learn preferences from residents facing barriers to expressing them directly.

Standard 3.4 · *Standard 3: Personal Care & Daily Living*

Guidance & Learning

GUIDANCE ASF-LTC-STD3-v3.0

WHY THIS STANDARD EXISTS

For a resident living in a facility long-term, food and activities are not incidental — they are a significant part of daily quality of life, and a program that ignores genuine cultural and personal preference treats residents as an undifferentiated group rather than the individuals they are, even when their ability to directly express that preference is affected by dementia or communication barriers.

The evidence: [14] The United Nations Principles for Older Persons establish that older persons should be able to live in environments adaptable to personal preferences, a principle reflected in established long-term care practice as the facility's responsibility to make reasonable efforts to learn and accommodate each resident's cultural and personal food preferences, including documented steps to learn preferences from residents facing barriers to expressing them directly.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Food and activities genuinely reflect individual cultural, religious, and personal preferences.	✗ A standardized program is applied uniformly regardless of individual background.
✓ Active, documented effort exists to learn preferences from residents with communication barriers.	✗ No documented effort exists to learn preferences from residents with communication barriers.
✓ Learned preferences are genuinely reflected in practice, not just recorded.	✗ Preferences are recorded but not genuinely acted on.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Major religious dietary requirements are accommodated but more individual personal preferences are not.**
Personal, non-religious preferences still carry real meaning for a resident's daily quality of life.

2 **Effort to learn preferences happens at admission but isn't revisited as dementia progresses and communication changes.**
A resident's ability to express preference, and preferences themselves, can genuinely change over time.

3 **Preferences are documented but the connection between documentation and actual daily provision is inconsistent.**
Documentation without genuine operational follow-through doesn't provide the real benefit this criterion exists to ensure.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current preference accommodation for genuine individualization versus standardized programming.

Week 2 Establish a specific, documented process for learning preferences from residents with communication barriers.

Week 3 Build a clear connection between documented preferences and actual daily food and activity provision.

Ongoing Revisit preference documentation as residents' communication ability changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff how they learned a specific resident's preferences, particularly one with dementia.
A specific, real example reveals genuine effort, not an assumption preferences can't be learned.

Compare documented preferences against what's actually provided to a specific resident.
This reveals whether documentation translates into genuine practice.

E-LEARNING academy.gmj.ge/ltc-std3-4-cultural-preference — 30 min · complete before self-assessment

Standard 3.5 **CORE** · *Standard 3: Personal Care & Daily Living*

A Qualified Activities Program Provides Genuine Social Engagement

ASSESSMENT ASF-LTC-STD3-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

3.5
CORE
L1

THE STANDARD

A Qualified Activities Program Provides Genuine Social Engagement

The facility provides an ongoing activities program led by a genuinely qualified activities professional, offering real, varied social and recreational engagement — not passive entertainment like a television left on, or a program that exists on paper without genuine resident participation.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is the activities program led by a genuinely qualified activities professional meeting defined qualification criteria?** *Specific, verified qualification, not simply a staff member assigned the role informally.* Doc: Activities professional qualification record	YES	PARTIAL	NO
2	**Does the program offer real, varied engagement matched to individual resident interests, not passive entertainment alone?** *Genuine variety and individual relevance, not a single default activity like television.* Doc: Activities program schedule and content	YES	PARTIAL	NO
3	**Is genuine resident participation observed, not just a program that exists on paper?** *Real, observed participation, not activities offered without residents actually engaging.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Activities professional qualification review*	Reviews the qualification of the person leading the activities program against defined criteria.
DOCUMENT *Program content review*	Reviews the activities program schedule for genuine variety matched to resident interests.
OBSERVE *Participation observation*	Observes an actual activity for genuine resident participation, not passive presence alone.

REFERENCES

[15] The United Nations Principles for Older Persons establish that older persons should be able to pursue opportunities for the full development of their potential and remain integrated in society, a principle reflected in established long-term care practice as requiring an ongoing activities program directed by a qualified activities professional to meet the interests and support the physical, mental, and psychosocial well-being of each resident.

Standard 3.5 · *Standard 3: Personal Care & Daily Living*

Guidance & Learning

GUIDANCE ASF-LTC-STD3-v3.0

WHY THIS STANDARD EXISTS

Social isolation and lack of meaningful engagement carry real, documented harm to a long-term resident's psychological wellbeing, and a facility that provides only passive entertainment, or an activities program that exists in name only, is failing a genuine, significant part of what quality of life means for someone living there long-term.

The evidence: [15] The United Nations Principles for Older Persons establish that older persons should be able to pursue opportunities for the full development of their potential and remain integrated in society, a principle reflected in established long-term care practice as requiring an ongoing activities program directed by a qualified activities professional to meet the interests and support the physical, mental, and psychosocial well-being of each resident.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The activities program is led by a genuinely, verifiably qualified professional.	✗ The activities role is filled informally without meeting defined qualification criteria.
✓ The program offers real, varied engagement matched to individual interests.	✗ The program defaults to passive entertainment with little genuine variety.
✓ Genuine resident participation is observed, not just programmed availability.	✗ Activities exist on the schedule but residents don't genuinely participate.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **The activities professional is qualified but the program isn't adapted for residents with significant cognitive impairment.**
Meaningful engagement needs to be genuinely accessible to residents across the full range of cognitive ability.

2 **Variety exists on the schedule but actual attendance is concentrated in a small group of residents.**
A program's real value depends on genuinely reaching residents broadly, not just being available.

3 **Group activities are offered but residents who prefer individual engagement have fewer genuine options.**
Meaningful engagement looks different for different residents, and a program should genuinely reflect that.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review activities professional qualification against defined criteria.

Week 2 Assess program variety and adaptation for residents with cognitive impairment.

Week 3 Establish tracking of genuine resident participation, not just program offerings.

Ongoing Review participation patterns and adjust programming to reach residents more broadly.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual activity session directly, watching for genuine participation, not passive presence.
Direct observation reveals whether engagement is real, not just scheduled.

Ask to see the activities professional's specific qualification credentials.
Specific, verifiable credentials are the real evidence of genuine qualification, not an assumed title.

E-LEARNING academy.gmj.ge/ltc-std3-5-activities-program — 30 min · complete before self-assessment

STANDARD 4

Clinical & Medical Care

MANDATORY

5 criteria

Standard 4.1 **NON-NEGOTIABLE** · *Standard 4: Clinical & Medical Care*

Monthly Pharmacist Medication Review Actually Catches Unnecessary Drugs

ASSESSMENT ASF-LTC-STD4-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.1
NON-NEGOTIABLE
L1

THE STANDARD

Monthly Pharmacist Medication Review Actually Catches Unnecessary Drugs

A licensed pharmacist reviews every resident's complete drug regimen at least monthly, with any irregularity — excessive dose, excessive duration, inadequate monitoring, inadequate indication — specifically reported to the attending physician and acted upon, not a review that occurs on schedule but produces no real consequence.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does a licensed pharmacist review every resident's complete drug regimen at least monthly?** *A genuine, complete review, not a partial check or one that lapses under pressure.* Doc: Monthly pharmacist review record	YES	PARTIAL	NO
2	**Are identified irregularities specifically reported to the attending physician, medical director, and director of nursing?** *Specific, documented reporting to the right people, not an informal or incomplete escalation.* Doc: Irregularity reporting record	YES	PARTIAL	NO
3	**Is there real evidence that reported irregularities are actually acted upon, not just noted and filed?** *Genuine action resulting from the report, not a report that produces no real consequence.* Doc: Irregularity resolution record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Monthly review record check*	Reviews pharmacist review records for consistent, complete monthly coverage of every resident.
DOCUMENT *Irregularity reporting review*	Reviews evidence that identified irregularities are specifically reported to the correct individuals.
ASK *Resolution outcome interview*	Asks staff for a real example of an irregularity that was identified and what actually happened as a result.

REFERENCES

[16] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require regular licensed pharmacist review of each resident's complete drug regimen, with identified irregularities reported to the attending physician, medical director, and director of nursing, and acted upon.

Standard 4.1 · *Standard 4: Clinical & Medical Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD4-v3.0

WHY THIS STANDARD EXISTS

An unnecessary drug — one given at excessive dose, for excessive duration, or without adequate ongoing indication — can cause real harm that accumulates quietly over time, and a monthly pharmacist review exists specifically to catch this systematically, not leave it to be noticed only if something visibly goes wrong.

The evidence: [16] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require regular licensed pharmacist review of each resident's complete drug regimen, with identified irregularities reported to the attending physician, medical director, and director of nursing, and acted upon.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every resident receives a genuine, complete monthly pharmacist review. ✓ Irregularities are specifically reported to the attending physician, medical director, and director of nursing. ✓ Real evidence shows reported irregularities are genuinely acted upon.	✗ Pharmacist review is inconsistent, partial, or lapses for some residents. ✗ Irregularities are identified but not specifically reported to the required individuals. ✗ Reports produce no documented action or resolution.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Review happens monthly but doesn't consistently cover every category of potential irregularity.**
A review that misses a category of concern provides only partial protection.

2 **Reporting happens but response time from the attending physician is inconsistent.**
A report without a prompt, genuine response doesn't provide the real protection this process is meant to ensure.

3 **Irregularities are resolved for individual cases but patterns across residents aren't reviewed collectively.**
A pattern across multiple residents can reveal a systemic issue that individual case review alone would miss.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current pharmacist review practice for consistency and completeness.

Week 2 Establish clear reporting pathways to the attending physician, medical director, and director of nursing.

Week 3 Build a tracking process confirming irregularities lead to genuine action.

Ongoing Review irregularity patterns across residents for systemic issues.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent example of an irregularity and trace it through to its actual resolution.
A real, traced example reveals whether the process genuinely functions, not just exists on paper.

Ask the attending physician how quickly they typically respond to a pharmacist-identified irregularity.
A specific, confident answer reveals genuine, prompt engagement with the process.

E-LEARNING academy.gmj.ge/ltc-std4-1-pharmacist-review — 30 min · complete before self-assessment

Standard 4.2 **NON-NEGOTIABLE** · *Standard 4: Clinical & Medical Care*

Psychotropic Medications Require a Documented, Specific Diagnosis, Not General Behavior Management

ASSESSMENT ASF-LTC-STD4-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.2
NON-NEGOTIABLE
L1

THE STANDARD

Psychotropic Medications Require a Documented, Specific Diagnosis, Not General Behavior Management

A resident is never started on a psychotropic medication without a specific, diagnosed, clinically documented condition justifying its use — never as a general response to behavior, agitation, or the convenience of managing a resident who is difficult to care for.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every psychotropic medication tied to a specific, diagnosed condition documented in the clinical record?** *A specific, documented diagnosis, not a general behavioral rationale.* Doc: Psychotropic medication diagnosis documentation	YES	PARTIAL	NO
2	**Are non-pharmacological, behavioral approaches genuinely tried first, before psychotropic medication is started?** *Real, attempted alternatives, not psychotropic medication as the default first response.* Doc: Behavioral intervention documentation	YES	PARTIAL	NO
3	**Can staff describe the specific diagnosed condition behind a particular resident's psychotropic medication?** *Specific, genuine knowledge, not a general sense that the medication helps with behavior.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Diagnosis documentation review*	Reviews psychotropic medication orders for a specific, documented diagnosed condition, not general behavior rationale.
DOCUMENT *Behavioral intervention review*	Reviews documentation of non-pharmacological approaches genuinely attempted before medication initiation.
ASK *Staff knowledge interview*	Asks staff to describe the specific diagnosed condition behind a particular resident's psychotropic medication.

REFERENCES

[17] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit psychotropic drug use unless necessary to treat a specific condition that is diagnosed and documented in the resident's clinical record.

Standard 4.2 · *Standard 4: Clinical & Medical Care*
Guidance & Learning

GUIDANCE ASF-LTC-STD4-v3.0

WHY THIS STANDARD EXISTS

Using psychotropic medication as a general behavior management tool, rather than treatment for a specifically diagnosed condition, is one of the most well-documented and serious patterns of harm in long-term care — it can leave a resident over-sedated, at higher fall and mortality risk, and chemically restrained in substance if not in name.

The evidence: [17] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit psychotropic drug use unless necessary to treat a specific condition that is diagnosed and documented in the resident's clinical record.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every psychotropic medication is tied to a specific, documented diagnosis.	✗ Psychotropic medication is used as a general response to behavior or agitation.
✓ Non-pharmacological approaches are genuinely tried first.	✗ No genuine attempt at non-pharmacological approaches precedes medication.
✓ Staff can describe the specific condition behind a resident's medication.	✗ Staff describe the medication's purpose only in general behavioral terms.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **New psychotropic orders have specific documented diagnoses but older, long-standing orders lack the same clarity.**
Every psychotropic medication deserves the same documented justification, regardless of when it was originally started.

2 **Behavioral approaches are documented as considered but the actual attempt isn't clearly described.**
Considering an alternative isn't the same as genuinely attempting it before resorting to medication.

3 **Diagnosis documentation exists but isn't consistently reviewed for continued accuracy over time.**
A diagnosis justifying ongoing medication should remain genuinely accurate, not simply carried forward indefinitely.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current psychotropic medication orders for specific, documented diagnostic justification.

Week 2 Establish or strengthen non-pharmacological intervention practice and documentation.

Week 3 Train staff on the specific diagnosed conditions behind each resident's psychotropic medications.

Ongoing Review long-standing psychotropic orders for continued diagnostic accuracy.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask about a specific, long-standing psychotropic order, not only recently started ones.
This is where documentation most commonly grows stale or unclear over time.

Ask a front-line staff member, not only a nurse, what the medication is specifically for.
This reveals whether specific understanding genuinely extends through the care team.

E-LEARNING academy.gmj.ge/ltc-std4-2-psychotropic-diagnosis — 30 min · complete before self-assessment

Standard 4.3 **NON-NEGOTIABLE** · *Standard 4: Clinical & Medical Care*

Gradual Dose Reduction Is Genuinely Attempted for Psychotropic Medications

ASSESSMENT ASF-LTC-STD4-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.3
NON-NEGOTIABLE
L1

THE STANDARD

Gradual Dose Reduction Is Genuinely Attempted for Psychotropic Medications

Residents on psychotropic medication receive genuine, documented gradual dose reduction attempts combined with behavioral interventions, unless a specific clinical reason makes this genuinely contraindicated — not medication continued indefinitely without any real attempt to reduce or discontinue it.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does every resident on psychotropic medication have a genuine, documented gradual dose reduction attempt?** *A real, documented attempt, not medication continued indefinitely by default.* Doc: Gradual dose reduction documentation	YES	PARTIAL	NO
2	**Where gradual dose reduction is considered clinically contraindicated, is the specific clinical reason documented?** *A specific, documented clinical justification, not contraindication assumed without real basis.* Doc: Contraindication documentation	YES	PARTIAL	NO
3	**Are behavioral interventions combined with dose reduction attempts, not medication reduction alone?** *Genuine combined approach, not dose reduction attempted in isolation.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Dose reduction attempt review*	Reviews documentation of genuine, attempted gradual dose reduction for residents on psychotropic medication.
DOCUMENT *Contraindication justification review*	Reviews the specific, documented clinical reasoning behind any contraindication determination.
ASK *Combined approach interview*	Asks staff whether behavioral interventions are genuinely combined with dose reduction attempts.

REFERENCES

[18] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require residents using psychotropic drugs to receive gradual dose reduction and behavioral interventions, unless clinically contraindicated, in a genuine effort to discontinue these drugs.

Standard 4.3 · *Standard 4: Clinical & Medical Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD4-v3.0

WHY THIS STANDARD EXISTS

A psychotropic medication that was genuinely needed at one point may not remain needed indefinitely, and without a real, ongoing effort to reduce dose where clinically appropriate, a resident can remain on medication — and its real risks — far longer than actually necessary, simply because no one made the effort to check.

The evidence: [18] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require residents using psychotropic drugs to receive gradual dose reduction and behavioral interventions, unless clinically contraindicated, in a genuine effort to discontinue these drugs.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every resident on psychotropic medication has a genuine, documented reduction attempt.	✗ Medication continues indefinitely with no documented reduction attempt.
✓ Contraindication, where determined, is backed by specific documented clinical reasoning.	✗ Contraindication is assumed or undocumented, without real clinical basis.
✓ Behavioral interventions are genuinely combined with reduction attempts.	✗ Dose reduction, if attempted, happens without any behavioral intervention alongside it.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Reduction attempts happen for some residents but not consistently across the full population on psychotropic medication.**
Every resident on this medication deserves the same genuine, periodic reconsideration.

2 **Contraindication documentation exists but doesn't specifically address why this particular resident's situation warrants it.**
A generic contraindication rationale doesn't reflect the genuine, individual clinical judgement this requires.

3 **Reduction is attempted but not systematically tracked to know whether it was ultimately successful.**
Without tracking outcomes, a facility can't learn whether its reduction efforts are genuinely working.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current psychotropic medication population for documented reduction attempts.

Week 2 Establish a systematic process for periodic dose reduction consideration.

Week 3 Build genuine behavioral intervention practice alongside reduction attempts.

Ongoing Track reduction attempt outcomes to inform future practice.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a specific resident's dose reduction history over the past year.
A real, traceable history reveals whether reduction is genuinely attempted, not just theoretically required.

Ask what behavioral intervention accompanied a specific reduction attempt.
A specific, real answer reveals genuine combined practice, not medication-only reduction.

E-LEARNING academy.gmj.ge/ltc-std4-3-gradual-dose-reduction — 30 min · complete before self-assessment

	Standard 4.4 **NON-NEGOTIABLE** · *Standard 4: Clinical & Medical Care* **PRN Psychotropic Orders Are Time-Limited and Re-Evaluated, Not Renewed Automatically**	**ASSESSMENT** ASF-LTC-STD4-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.4
NON-NEGOTIABLE
L1

THE STANDARD

PRN Psychotropic Orders Are Time-Limited and Re-Evaluated, Not Renewed Automatically

As-needed psychotropic medication orders are limited to 14 days, with antipsychotic PRN orders specifically requiring a physician re-evaluation before any renewal — not extended or renewed automatically as a matter of routine.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are all PRN psychotropic orders genuinely limited to 14 days, not extended automatically?** *A genuine, enforced 14-day limit, not a routine extension.* Doc: PRN order duration record	YES	PARTIAL	NO
2	**Does any PRN antipsychotic renewal require a genuine physician re-evaluation, not automatic continuation?** *A real, documented re-evaluation specifically for antipsychotics, not a rubber-stamp renewal.* Doc: Antipsychotic renewal re-evaluation documentation	YES	PARTIAL	NO
3	**Where a PRN order is extended beyond 14 days for a non-antipsychotic, is the physician's rationale specifically documented?** *A specific, documented clinical rationale, not an extension without real justification.* Doc: Extension rationale documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *PRN order duration review*	Reviews PRN psychotropic order records for genuine 14-day limit enforcement.
DOCUMENT *Antipsychotic re-evaluation review*	Reviews documentation of genuine physician re-evaluation before any antipsychotic PRN renewal.
ASK *Renewal practice interview*	Asks prescribing staff how PRN psychotropic renewal genuinely works in practice.

REFERENCES

[19] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, limit as-needed psychotropic orders to a short, defined duration, with as-needed antipsychotic orders specifically prohibited from renewal unless the attending physician or prescribing practitioner evaluates the resident for continued appropriateness.

Standard 4.4 · *Standard 4: Clinical & Medical Care*
Guidance & Learning

GUIDANCE ASF-LTC-STD4-v3.0

WHY THIS STANDARD EXISTS

An as-needed psychotropic order that simply keeps renewing without genuine re-evaluation can drift into de facto long-term, unmonitored use — the 14-day limit exists specifically to force a genuine clinical checkpoint, not to be treated as a paperwork formality that gets renewed without real reconsideration.

The evidence: [19] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, limit as-needed psychotropic orders to a short, defined duration, with as-needed antipsychotic orders specifically prohibited from renewal unless the attending physician or prescribing practitioner evaluates the resident for continued appropriateness.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ PRN psychotropic orders are genuinely limited to 14 days.	✗ PRN orders are routinely extended or renewed without genuine time limits.
✓ Antipsychotic PRN renewal requires a real, documented physician re-evaluation.	✗ Antipsychotic renewal happens without real re-evaluation.
✓ Any extension beyond 14 days carries specific, documented clinical rationale.	✗ Extensions lack specific clinical rationale.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **The 14-day limit is tracked for most orders but occasionally lapses during staff transitions.**
Consistent tracking regardless of staffing changes is what makes this limit genuinely reliable.

2 **Re-evaluation happens for antipsychotic renewals but isn't always documented with specific clinical detail.**
Undocumented re-evaluation is difficult to distinguish from renewal without genuine reconsideration.

3 **Extension rationale is documented but sometimes generic rather than specific to the individual resident's situation.**
A specific, individual rationale is what distinguishes genuine clinical judgement from routine extension.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current PRN psychotropic order tracking for genuine 14-day limit enforcement.

Week 2 Establish a specific re-evaluation process required before any antipsychotic PRN renewal.

Week 3 Train prescribing staff on documentation requirements for any extension beyond 14 days.

Ongoing Audit PRN order duration and renewal documentation for continued compliance.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a specific, real example of an antipsychotic PRN renewal and its re-evaluation documentation.
A real, traceable example reveals whether re-evaluation is genuine practice, not a formality.

Check PRN order tracking during a period of staff transition or turnover.
This is where consistent enforcement of the time limit is most likely to lapse.

E-LEARNING academy.gmj.ge/ltc-std4-4-prn-psychotropic-limits — 30 min · complete before self-assessment

	Standard 4.5 **NON-NEGOTIABLE** · *Standard 4: Clinical & Medical Care* **Infection Control Follows a Defined, Facility-Specific Program**	**ASSESSMENT** ASF-LTC-STD4-v3.0
CR ADAPTED	**TR** FULL	**SM** FULL	**ST** FULL

4.5
NON-NEGOTIABLE
L1

THE STANDARD

Infection Control Follows a Defined, Facility-Specific Program

The facility maintains an infection prevention and control program specific to its own resident population and physical environment, with a designated, trained infection preventionist — not a generic infection control policy adopted without genuine adaptation to this facility's actual circumstances.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the infection control program genuinely reflect this facility's own resident population and physical environment?** *Facility-specific adaptation, not a generic policy adopted without genuine customization.* Doc: Infection control program documentation	YES	PARTIAL	NO
2	**Is there a designated, trained infection preventionist with genuine responsibility for the program?** *A specific, trained, designated individual, not an informal or shared responsibility.* Doc: Infection preventionist designation and training record	YES	PARTIAL	NO
3	**Is the program genuinely reviewed and updated based on the facility's own actual assessment, not left static?** *Real, ongoing adaptation, not a program written once and never revisited.* Doc: Program review and update record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Program specificity review*	Reviews the infection control program for genuine, facility-specific content, not generic policy.
DOCUMENT *Infection preventionist designation review*	Reviews the designation and training of the facility's infection preventionist.
DOCUMENT *Program update review*	Reviews evidence that the program is genuinely reviewed and updated based on facility assessment.

REFERENCES

[20] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to establish and maintain an infection prevention and control program based on the facility's own assessment, with a designated infection preventionist holding specific training.

Standard 4.5 · *Standard 4: Clinical & Medical Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD4-v3.0

WHY THIS STANDARD EXISTS

Long-term care residents often have specific, elevated infection vulnerability — chronic conditions, close communal living, shared care staff across many residents — and a generic infection control policy that doesn't reflect this facility's actual population and physical environment misses the specific risks most likely to actually cause harm here.

The evidence: [20] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to establish and maintain an infection prevention and control program based on the facility's own assessment, with a designated infection preventionist holding specific training.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The infection control program genuinely reflects this facility's specific population and environment.	✗ A generic infection control policy is adopted without facility-specific adaptation.
✓ A designated, trained infection preventionist holds real responsibility for the program.	✗ No specific, trained individual holds genuine responsibility for infection control.
✓ The program is genuinely reviewed and updated, not static.	✗ The program hasn't been reviewed or updated in a meaningful timeframe.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **An infection preventionist is designated but their specific training doesn't fully meet defined requirements.**
The role's real protective value depends on genuine, adequate training, not designation alone.

2 **The program addresses common infection risks but doesn't specifically reflect this facility's particular resident population.**
Generic coverage of common risks can still miss what's specifically relevant to this facility's actual circumstances.

3 **Program review happens but doesn't consistently incorporate genuinely current facility assessment data.**
A review that doesn't use current, real data provides limited genuine improvement over a static program.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current infection control program for genuine facility-specific adaptation.

Week 2 Confirm or establish infection preventionist designation and training against defined requirements.

Week 3 Establish a genuine, scheduled program review process incorporating current facility assessment.

Ongoing Update the infection control program as facility circumstances genuinely change.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the infection preventionist to describe a specific risk factor unique to this facility's population.
A specific, informed answer reveals genuine facility-specific engagement, not a generic role.

Ask when the program was last genuinely reviewed and what changed as a result.
A specific, real answer reveals whether review is genuine practice, not just a stated requirement.

E-LEARNING academy.gmj.ge/ltc-std4-5-infection-control — 30 min · complete before self-assessment

STANDARD 5

Cognitive & Behavioral Care

MANDATORY

5 criteria

Standard 5.1 **NON-NEGOTIABLE** · *Standard 5: Cognitive & Behavioral Care*

Behavioral Expressions Are Understood as Communication, Not Managed as Problems

ASSESSMENT ASF-LTC-STD5-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

5.1
NON-NEGOTIABLE
L1

THE STANDARD

Behavioral Expressions Are Understood as Communication, Not Managed as Problems

Staff are trained to understand behavioral expressions — agitation, resistance to care, repetitive movement — as genuine communication of an unmet need or distress, with a specific process to identify and address the underlying cause, not a default response aimed only at stopping the behavior itself.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are staff trained to understand behavioral expressions as communication of an unmet need, not as problems to be stopped?** *Genuine understanding of behavior as communication, not framed only as disruption to manage.* Doc: Staff training record on behavioral expressions	YES	PARTIAL	NO
2	**Is there a specific process to identify the underlying cause behind a behavioral expression?** *A real, structured process, not an assumption that the cause is simply the dementia itself.* Doc: Behavioral assessment documentation	YES	PARTIAL	NO
3	**Does the response address the identified underlying need, not only aim to stop the visible behavior?** *A response matched to the genuine cause, not suppression of the behavior alone.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Staff training review*	Reviews training content for genuine coverage of behavioral expressions as communication.
DOCUMENT *Underlying cause assessment review*	Reviews documentation for a structured process identifying the cause behind behavioral expressions.
OBSERVE *Response practice observation*	Observes an actual staff response to a behavioral expression for genuine cause-directed care.

REFERENCES

[21] Cohen-Mansfield J. The Unmet Needs Framework for understanding behavioral expressions in dementia, as applied in current long-term care practice, identifies behavior as communication of underlying emotional or physical distress rather than pathology to be suppressed, requiring identification and response to the genuine underlying need.

Standard 5.1 · *Standard 5: Cognitive & Behavioral Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD5-v3.0

WHY THIS STANDARD EXISTS

A behavior that looks disruptive from the outside is often the only way a resident with advanced dementia can communicate hunger, pain, overstimulation, or fear, and responding only to suppress the behavior — rather than understanding and addressing what's actually driving it — leaves the genuine underlying need unmet, and often makes the behavior worse.

The evidence: [21] Cohen-Mansfield J. The Unmet Needs Framework for understanding behavioral expressions in dementia, as applied in current long-term care practice, identifies behavior as communication of underlying emotional or physical distress rather than pathology to be suppressed, requiring identification and response to the genuine underlying need.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff genuinely understand and describe behavioral expressions as communication.	✗ Staff describe behaviors only as problems to manage or stop.
✓ A structured process identifies the underlying cause behind each expression.	✗ No structured process exists to identify underlying causes.
✓ Responses address the genuine underlying need, not just the visible behavior.	✗ Responses aim only to suppress the visible behavior, regardless of its cause.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Understanding is strong among nursing staff but less consistently reinforced with support staff who spend significant time with residents.**
Any staff member interacting with a resident benefits from genuinely understanding behavior as communication.

2 **Cause identification happens for more disruptive expressions but not consistently for quieter, less visible ones.**
A quieter expression of distress deserves the same genuine attention as a more visible one.

3 **The underlying cause is identified but the response doesn't consistently address it directly.**
Identifying a cause without a genuinely matched response doesn't provide the real benefit this approach is meant to offer.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current staff understanding and training on behavioral expressions as communication.

Week 2 Establish a structured underlying-cause assessment process.

Week 3 Train all staff, including support roles, on cause-directed response.

Ongoing Review behavioral response practice using real, recent examples.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a staff member to describe a recent behavioral expression and what they believe was actually driving it.
A specific, thoughtful answer reveals genuine understanding, not a memorized framework.

Ask a support staff member, not only nursing staff, about their understanding of behavioral expressions.
This reveals whether the approach genuinely extends beyond clinical staff.

E-LEARNING academy.gmj.ge/ltc-std5-1-behavioral-expressions — 30 min · complete before self-assessment

Standard 5.2 **NON-NEGOTIABLE** · *Standard 5: Cognitive & Behavioral Care*

Wandering Risk Is Assessed Using a Validated Tool, Not Informal Judgment

ASSESSMENT ASF-LTC-STD5-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

5.2
NON-NEGOTIABLE
L1

THE STANDARD

Wandering Risk Is Assessed Using a Validated Tool, Not Informal Judgment

Every resident with cognitive impairment is assessed for wandering and elopement risk using a validated, structured tool, at admission and after any significant change — not an informal, subjective judgement about which residents seem likely to wander.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every resident with cognitive impairment assessed for wandering risk using a validated, structured tool?** *A specific, validated assessment, not an informal staff impression.* Doc: Wandering risk assessment record	YES	PARTIAL	NO
2	**Is the assessment repeated after any significant change in the resident's cognitive or physical condition?** *Genuine reassessment reflecting the resident's current, actual risk, not a one-time evaluation.* Doc: Reassessment record	YES	PARTIAL	NO
3	**Does the assessment result specifically inform the resident's individual care plan?** *Genuine, individual application of the assessment, not a result recorded without practical use.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Assessment tool review*	Reviews the specific, validated tool used for wandering risk assessment.
DOCUMENT *Reassessment record review*	Reviews evidence that assessment is repeated after significant condition changes.
DOCUMENT *Care plan application review*	Reviews whether assessment results specifically inform the individual care plan.

REFERENCES

[22] Algase DL, Beattie ERA, Antonakos C, Beel-Bates CA, Yao L. Wandering and the physical environment. Am J Alzheimers Dis Other Demen. 2010 — establishes structured, validated wandering risk assessment, including the Algase Wandering Scale, as the standard for identifying elopement and wandering risk in long-term care, distinct from informal staff judgement.

Standard 5.2 · *Standard 5: Cognitive & Behavioral Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD5-v3.0

WHY THIS STANDARD EXISTS

Wandering is genuinely common — a majority of residents with dementia will experience at least one episode — and informal judgement about who is at risk is measurably less reliable than a structured, validated assessment that's specifically designed to capture the actual risk factors involved.

The evidence: [22] Algase DL, Beattie ERA, Antonakos C, Beel-Bates CA, Yao L. Wandering and the physical environment. Am J Alzheimers Dis Other Demen. 2010 — establishes structured, validated wandering risk assessment, including the Algase Wandering Scale, as the standard for identifying elopement and wandering risk in long-term care, distinct from informal staff judgement.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every resident with cognitive impairment receives a validated, structured wandering risk assessment.	✗ Wandering risk is judged informally, without a structured, validated tool.
✓ Reassessment genuinely happens after significant condition changes.	✗ Assessment happens only once, never updated as the resident's condition changes.
✓ Assessment results specifically inform the individual care plan.	✗ Assessment results are recorded but don't inform the actual care plan.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Assessment happens at admission but reassessment after a cognitive decline isn't consistently triggered.**
Wandering risk can change significantly as cognitive impairment progresses.

2 **The tool is used but not consistently by all staff conducting assessments.**
Consistent, correct use across all assessing staff is what makes a validated tool genuinely reliable.

3 **Assessment results are documented but the care plan doesn't specifically reflect identified risk factors.**
An assessment that doesn't translate into individual care planning provides limited real protective value.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current wandering risk assessment practice for validated tool use versus informal judgement.

Week 2 Train staff on consistent, correct administration of the validated assessment tool.

Week 3 Establish a specific reassessment trigger tied to significant condition changes.

Ongoing Confirm assessment results are genuinely reflected in individual care plans.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual validated assessment tool used, not a general description of risk judgement.
A specific, named tool is the real evidence of structured, validated practice.

Ask how a specific resident's wandering risk assessment translated into their actual care plan.
A specific, real example reveals genuine application, not assessment for its own sake.

E-LEARNING academy.gmj.ge/ltc-std5-2-wandering-assessment — 30 min · complete before self-assessment

Standard 5.3 **NON-NEGOTIABLE** · *Standard 5: Cognitive & Behavioral Care*

Elopement Prevention Balances Genuine Safety With Resident Autonomy

ASSESSMENT ASF-LTC-STD5-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

5.3
NON-NEGOTIABLE
L1

THE STANDARD

Elopement Prevention Balances Genuine Safety With Resident Autonomy

Elopement prevention measures are individualized and proportionate to actual assessed risk, genuinely balancing safety with the resident's autonomy and freedom of movement — not a blanket, facility-wide restriction, such as a locked unit, applied to every resident regardless of individual risk or need.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are elopement prevention measures individualized to the resident's actual assessed risk, not applied as a blanket facility-wide restriction?** *Genuine individualization matched to real risk, not uniform restriction regardless of individual need.* Doc: Individualized elopement prevention plan	YES	PARTIAL	NO
2	**Do residents with lower assessed risk retain genuine freedom of movement, not restricted by default?** *Real, preserved autonomy for lower-risk residents, not restriction applied to everyone regardless of risk level.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific, documented justification when a more restrictive measure is genuinely used for a specific resident?** *Specific, individual justification, not a default facility-wide policy.* Doc: Restrictive measure justification documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Individualization review*	Reviews elopement prevention plans for genuine individual tailoring to assessed risk.
OBSERVE *Autonomy preservation observation*	Observes whether lower-risk residents genuinely retain freedom of movement.
DOCUMENT *Restrictive measure justification review*	Reviews specific, individual documented justification for any more restrictive measure used.

REFERENCES

[23] Individualized, proportionate elopement prevention measures, balanced against resident autonomy and freedom of movement, are established practice in long-term care dementia management, distinct from blanket facility-wide restriction applied without individual justification.

Standard 5.3 · *Standard 5: Cognitive & Behavioral Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD5-v3.0

WHY THIS STANDARD EXISTS

A locked unit or restrictive environment might reduce elopement risk, but it also removes a resident's freedom of movement entirely, and established long-term care principles specifically require services that attain or maintain a resident's highest practicable well-being — a standard that a blanket restriction, applied without genuine individual justification, works directly against.

The evidence: [23] Individualized, proportionate elopement prevention measures, balanced against resident autonomy and freedom of movement, are established practice in long-term care dementia management, distinct from blanket facility-wide restriction applied without individual justification.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Elopement prevention is genuinely individualized to actual assessed risk.	✗ A blanket, facility-wide restriction is applied regardless of individual risk.
✓ Lower-risk residents retain genuine freedom of movement.	✗ All residents face the same restriction regardless of their actual assessed risk level.
✓ Any restrictive measure carries specific, individual documented justification.	✗ Restrictive measures lack specific, individual justification.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Individualization is genuine for the physical environment but less so for daily activity scheduling.**
Autonomy and safety balance extends beyond physical space alone to how a resident's day is genuinely structured.

2 **Lower-risk residents have some freedom but staff practice is inconsistent in genuinely respecting it.**
A policy of preserved autonomy needs consistent staff practice to provide real protection of resident freedom.

3 **Restrictive measures are individually justified initially but not periodically reconsidered as risk changes.**
A resident's genuine risk level can change, and restriction should be reconsidered accordingly, not left static.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current elopement prevention practice for genuine individualization versus blanket restriction.

Week 2 Establish individualized prevention plans matched to actual assessed risk.

Week 3 Train staff on genuinely preserving autonomy for lower-risk residents.

Ongoing Periodically reconsider restrictive measures as individual risk genuinely changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see elopement prevention plans for two different residents with different risk levels.
Genuinely different plans reveal real individualization; identical plans reveal a blanket approach.

Ask a lower-risk resident or their family about their actual freedom of movement in daily practice.
This tests lived experience, not just policy intent.

E-LEARNING academy.gmj.ge/ltc-std5-3-elopement-autonomy-balance — 30 min · complete before self-assessment

Standard 5.4 **NON-NEGOTIABLE** · *Standard 5: Cognitive & Behavioral Care*

Dementia Care Staff Receive Specific, Ongoing Training, Not General Orientation Alone

ASSESSMENT ASF-LTC-STD5-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

5.4
NON-NEGOTIABLE
L1

THE STANDARD

Dementia Care Staff Receive Specific, Ongoing Training, Not General Orientation Alone

Staff providing direct care to residents with dementia receive specific, ongoing dementia care training — communication techniques, behavioral expression response, person-centered approach — not a single general orientation session treated as sufficient for the duration of their employment.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Do staff providing direct dementia care receive specific training beyond general orientation?** *Specific, dementia-focused training content, not folded into general orientation alone.* Doc: Dementia-specific training record	YES	PARTIAL	NO
2	**Is this training genuinely ongoing, not a single session treated as sufficient indefinitely?** *Real, recurring training, not a one-time requirement.* Doc: Ongoing training schedule	YES	PARTIAL	NO
3	**Can staff demonstrate specific dementia care skills — communication technique, behavioral response — not just describe general awareness?** *Genuine, demonstrable skill, not familiarity with the concept alone.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Training content review*	Reviews training content for specific dementia care focus, not general orientation alone.
DOCUMENT *Ongoing training schedule review*	Reviews the schedule and actual delivery of recurring dementia care training.
OBSERVE *Skill demonstration observation*	Observes staff demonstrating specific dementia care communication and response skills.

REFERENCES

[24] Tilly J, Reed P. Dementia Care Practice Recommendations for Assisted Living and Nursing Homes. Chicago: Alzheimer's Association — establishes specific, ongoing dementia care training, including communication techniques and person-centered approach, as distinct from general staff orientation, as a core practice recommendation for long-term care.

Standard 5.4 · *Standard 5: Cognitive & Behavioral Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD5-v3.0

WHY THIS STANDARD EXISTS

Dementia care requires genuinely specific skills that differ meaningfully from general caregiving, and a single orientation session, however thorough, doesn't provide the ongoing reinforcement and skill development that genuinely effective dementia care requires over the course of a career.

The evidence: [24] Tilly J, Reed P. Dementia Care Practice Recommendations for Assisted Living and Nursing Homes. Chicago: Alzheimer's Association — establishes specific, ongoing dementia care training, including communication techniques and person-centered approach, as distinct from general staff orientation, as a core practice recommendation for long-term care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff receive specific, dementia-focused training distinct from general orientation.	✗ Dementia care content is folded into general orientation with no specific focus.
✓ Training is genuinely ongoing and recurring, not a single session.	✗ Training happens once and is never repeated or reinforced.
✓ Staff can demonstrate specific, genuine dementia care skills.	✗ Staff can describe general awareness but cannot demonstrate specific skills.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Initial training is specific and thorough but ongoing reinforcement is inconsistent.**
Skill retention and development genuinely benefit from recurring reinforcement, not a strong single session alone.

2 **Nursing staff receive specific training but support and ancillary staff receive less.**
Any staff member interacting with residents benefits from genuine dementia care skill, not clinical staff alone.

3 **Training covers communication technique well but behavioral expression response less thoroughly.**
Both are genuinely distinct, important skills, and training should cover both with real depth.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current dementia care training for specificity versus general orientation content.

Week 2 Build or strengthen specific training content covering communication and behavioral response.

Week 3 Establish a recurring training schedule reaching all staff who interact with residents.

Ongoing Assess staff skill demonstration periodically, not just training completion.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a support staff member, not only nursing staff, about their dementia care training.
This reveals whether specific training genuinely reaches everyone who interacts with residents.

Ask staff to demonstrate, not just describe, a specific communication technique.
Demonstration reveals genuine skill, not just familiarity with training content.

E-LEARNING academy.gmj.ge/ltc-std5-4-dementia-staff-training — 30 min · complete before self-assessment

Standard 5.5 **CORE** · *Standard 5: Cognitive & Behavioral Care*

A Resident's Individual Life History Genuinely Shapes Their Care

ASSESSMENT ASF-LTC-STD5-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

5.5
CORE
L1

THE STANDARD

A Resident's Individual Life History Genuinely Shapes Their Care

Each resident's individual life history — career, family, meaningful roles, personal preferences — is genuinely gathered and actively used to shape their daily care and activity engagement, not collected once as an intake formality and never referenced again.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is each resident's individual life history genuinely gathered, not skipped or treated as optional?** *Real, gathered life history information, not an assumption it's unnecessary or too difficult to obtain.* Doc: Life history documentation	YES	PARTIAL	NO
2	**Is this information actively used to shape daily care and activity engagement, not filed away unused?** *Genuine, ongoing use, not information collected once and never referenced.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Can staff describe a specific way a resident's life history has genuinely shaped their care approach?** *A specific, real example, not a general statement that life history is considered.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Life history gathering review*	Reviews documentation for genuine, gathered individual life history for each resident.
OBSERVE *Care application observation*	Observes whether life history information is genuinely reflected in actual daily care and activities.
ASK *Staff example interview*	Asks staff for a specific example of a resident's life history shaping their care approach.

REFERENCES

[25] Edvardsson D, Winblad B, Sandman PO. Person-centered care of people with severe Alzheimer's disease: current status and ways forward. Lancet Neurol. 2008;7(4):362-367 — establishes genuine use of individual life history and personhood, not cognitive status alone, as foundational to effective person-centered dementia care.

Standard 5.5 · *Standard 5: Cognitive & Behavioral Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD5-v3.0

WHY THIS STANDARD EXISTS

Person-centered dementia care is grounded in the understanding that personhood and identity aren't lost with cognitive decline, and a resident's genuine life history is often the key to understanding what a specific behavioral expression means, or what activity would genuinely engage them — information gathered but never used provides none of this real value.

The evidence: [25] Edvardsson D, Winblad B, Sandman PO. Person-centered care of people with severe Alzheimer's disease: current status and ways forward. Lancet Neurol. 2008;7(4):362-367 — establishes genuine use of individual life history and personhood, not cognitive status alone, as foundational to effective person-centered dementia care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Individual life history is genuinely gathered for every resident.	✗ Life history gathering is skipped or minimal.
✓ Life history information is actively used to shape daily care and activities.	✗ Information is collected but never referenced in actual daily care.
✓ Staff can describe specific, real examples of life history shaping care.	✗ Staff cannot describe any specific example of life history informing care.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Life history is gathered at admission but not updated as family provides additional information over time.**
A resident's history often emerges gradually through ongoing family relationships, not only at a single intake conversation.

2 **Information is used for activity planning but less consistently for understanding behavioral expressions.**
Life history carries real value for interpreting behavior, not only for planning activities.

3 **Some staff genuinely use this information but it isn't consistently shared across the full care team.**
Genuine benefit depends on this information reaching everyone providing care, not staying with whoever gathered it.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current life history gathering practice for completeness and genuine depth.

Week 2 Establish a process for life history information to genuinely reach the full care team.

Week 3 Train staff on connecting life history to both activity planning and behavioral understanding.

Ongoing Update life history documentation as new information emerges through family relationships.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a staff member for a specific detail from a resident's life history and how it shapes their approach.
A specific, real answer reveals genuine use, not documentation for its own sake.

Ask a family member whether they feel the facility genuinely knows their relative as an individual.
This tests lived experience of person-centered care, not documentation completeness alone.

E-LEARNING academy.gmj.ge/ltc-std5-5-life-history-care — 30 min · complete before self-assessment

STANDARD 6

End-of-Life & Palliative Care

MANDATORY

5 criteria

Standard 6.1 **NON-NEGOTIABLE** · *Standard 6: End-of-Life & Palliative Care*

Advance Directives Are Discussed Proactively, Not Only When a Crisis Arrives

ASSESSMENT ASF-LTC-STD6-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.1
NON-NEGOTIABLE
L1

THE STANDARD

Advance Directives Are Discussed Proactively, Not Only When a Crisis Arrives

Every resident, or their legal representative, is proactively offered a genuine conversation about advance directives and life-sustaining treatment preferences at admission and periodically thereafter — not first raised during a medical crisis, when there is far less time and far more distress to make a considered decision.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every resident or representative proactively offered a genuine advance directive conversation at admission?** *A real, offered conversation, not paperwork provided without discussion.* Doc: Advance directive conversation record	YES	PARTIAL	NO
2	**Is this conversation revisited periodically, not held once and never referenced again?** *Genuine, periodic revisiting, not a single admission-only conversation.* Doc: Periodic review record	YES	PARTIAL	NO
3	**Are documented preferences genuinely accessible to staff at the moment they're actually needed?** *Real, practical accessibility in a genuine emergency, not a document filed away and hard to locate.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Advance directive conversation review*	Reviews documentation of genuine, proactive advance directive conversations at admission.
DOCUMENT *Periodic review record check*	Reviews evidence that advance directive preferences are genuinely revisited over time.
OBSERVE *Accessibility check*	Checks whether documented preferences would actually be accessible to staff during a real emergency.

REFERENCES

[26] The United Nations Principles for Older Persons establish the right of older persons to make decisions about their own care, a principle reflected in established long-term care practice as the resident's right to formulate advance directives, with the facility required to provide written information about these rights and to address resident complaints about facility non-compliance.

Standard 6.1 · *Standard 6: End-of-Life & Palliative Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD6-v3.0

WHY THIS STANDARD EXISTS

A decision about life-sustaining treatment made in the middle of a medical crisis, under real time pressure and emotional strain, is a fundamentally worse decision-making context than a calm, proactive conversation held well in advance — the resident's actual wishes deserve to be captured when there's genuinely time to consider them.

The evidence: [26] The United Nations Principles for Older Persons establish the right of older persons to make decisions about their own care, a principle reflected in established long-term care practice as the resident's right to formulate advance directives, with the facility required to provide written information about these rights and to address resident complaints about facility non-compliance.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every resident or representative receives a genuine, proactive advance directive conversation.	✗ Advance directives are raised only during a medical crisis, if at all.
✓ Preferences are periodically revisited, not captured once and forgotten.	✗ Preferences are captured once at admission and never revisited.
✓ Documentation is genuinely accessible to staff when actually needed.	✗ Documentation exists but isn't practically accessible in a real emergency.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 The conversation happens at admission but isn't revisited even after a significant change in the resident's condition.
A resident's preferences, or their ability to express them, can genuinely change over time.

2 Documentation is thorough but stored in a way that's slow to locate during an actual emergency.
Documentation that exists but isn't practically accessible in the moment provides limited real protection.

3 Conversations happen with legal representatives but the resident themselves, where capable, isn't directly included.
A capable resident deserves genuine inclusion in decisions about their own end-of-life care.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current advance directive practice for genuine proactive conversation versus paperwork alone.

Week 2 Establish a periodic review schedule for advance directive preferences.

Week 3 Confirm documentation is genuinely, practically accessible during an emergency.

Ongoing Revisit preferences after any significant change in resident condition.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff how quickly they could locate a specific resident's advance directive during a real emergency.
A specific, confident answer reveals genuine practical accessibility, not just documentation existing somewhere.

Ask a resident or family member whether the conversation felt genuine, not just a form to sign.
This tests lived experience of the conversation, not documentation compliance alone.

E-LEARNING academy.gmj.ge/ltc-std6-1-advance-directives — 30 min · complete before self-assessment

Standard 6.2 **NON-NEGOTIABLE** · *Standard 6: End-of-Life & Palliative Care*

Palliative Care Is Available Regardless of Terminal Diagnosis

ASSESSMENT ASF-LTC-STD6-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

6.2
NON-NEGOTIABLE
L1

THE STANDARD

Palliative Care Is Available Regardless of Terminal Diagnosis

Palliative care — addressing physical, emotional, social, and spiritual suffering — is genuinely available to any resident who could benefit, not restricted to residents with a terminal diagnosis or treated as identical to, and conditional upon, hospice enrollment.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is palliative care genuinely available to any resident who could benefit, not restricted to those with a terminal diagnosis?** *Real availability independent of terminal prognosis, not conflated with hospice eligibility.* Doc: Palliative care availability documentation	YES	PARTIAL	NO
2	**Do staff genuinely understand the distinction between palliative care and hospice, not treat them as interchangeable?** *Genuine, accurate understanding of the real distinction, not confusion between the two.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does palliative care genuinely address physical, emotional, social, and spiritual suffering, not medical pain management alone?** *The full, genuine scope of palliative care, not a narrowed version limited to physical symptoms.* Doc: Palliative care scope documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Availability review*	Reviews whether palliative care is genuinely available independent of terminal diagnosis status.
ASK *Staff distinction interview*	Asks staff to explain the actual difference between palliative care and hospice.
DOCUMENT *Scope review*	Reviews palliative care documentation for genuine coverage beyond physical symptom management alone.

REFERENCES

[27] Established international clinical definitions of palliative care describe it as patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering, addressing physical, intellectual, emotional, social, and spiritual needs, distinct from and not conditional upon a terminal diagnosis or hospice election.

Standard 6.2 · *Standard 6: End-of-Life & Palliative Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD6-v3.0

WHY THIS STANDARD EXISTS

Palliative care and hospice are genuinely different things — palliative care requires no terminal prognosis at all, and a resident recovering from a serious injury or managing chronic pain can benefit from it just as much as someone with a terminal diagnosis. A facility that conflates the two, or makes palliative care conditional on a terminal diagnosis, denies real comfort-focused care to residents who could genuinely benefit from it.

The evidence: [27] Established international clinical definitions of palliative care describe it as patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering, addressing physical, intellectual, emotional, social, and spiritual needs, distinct from and not conditional upon a terminal diagnosis or hospice election.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Palliative care is genuinely available regardless of terminal diagnosis. ✓ Staff accurately understand and can explain the real distinction from hospice. ✓ Palliative care genuinely addresses the full range of suffering, not physical symptoms alone.	✗ Palliative care is treated as available only for residents with a terminal diagnosis. ✗ Staff conflate palliative care with hospice, treating them as the same thing. ✗ Palliative care is narrowed to physical pain management alone.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Physical symptom management is genuinely available broadly but emotional and spiritual support is less consistently offered.**
Genuine palliative care addresses the full range of suffering, not physical symptoms in isolation.

2 **Some staff understand the real distinction from hospice but others use the terms interchangeably.**
Consistent, accurate understanding across the full care team matters for residents to receive appropriate access.

3 **Palliative care is offered when a resident or family specifically asks but not proactively identified as an option.**
A resident or family may not know to ask if they're not aware palliative care is a genuinely separate, broader option.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current palliative care access for genuine independence from terminal diagnosis status.

Week 2 Train staff specifically on the real distinction between palliative care and hospice.

Week 3 Expand palliative care scope to genuinely address emotional, social, and spiritual suffering.

Ongoing Proactively identify and offer palliative care to residents who could genuinely benefit.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a staff member to explain the actual difference between palliative care and hospice.
A clear, accurate answer reveals genuine understanding, not assumed familiarity.

Ask about palliative care for a resident without a terminal diagnosis specifically.
This tests whether availability is genuinely independent of terminal status, not conflated with hospice eligibility.

E-LEARNING academy.gmj.ge/ltc-std6-2-palliative-care-access — 30 min · complete before self-assessment

	Standard 6.3 NON-NEGOTIABLE · *Standard 6: End-of-Life & Palliative Care* **Hospice Coordination Follows a Real, Written Agreement, Not Informal Handoff**	ASSESSMENT ASF-LTC-STD6-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.3
NON-NEGOTIABLE
L1

THE STANDARD

Hospice Coordination Follows a Real, Written Agreement, Not Informal Handoff

When a resident elects hospice care, the facility and the hospice agency operate under a specific, written agreement clearly defining who is responsible for each service — not an informal handoff where responsibility gaps go unnoticed until something is missed.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a specific, written agreement with the hospice agency defining responsibility for each service?** *A real, specific written agreement, not an informal or assumed division of responsibility.* Doc: Hospice coordination agreement	YES	PARTIAL	NO
2	**Can staff clearly identify who is responsible for a specific aspect of a hospice resident's care?** *Specific, confident knowledge of the actual division of responsibility, not uncertainty or assumption.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a real, documented process for identifying and closing a coordination gap if one is discovered?** *An active process for catching gaps, not an assumption the written agreement alone prevents them.* Doc: Coordination gap identification process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Written agreement review*	Reviews the actual written agreement with the hospice agency for specific responsibility definitions.
ASK *Staff responsibility interview*	Asks staff to identify who is responsible for a specific element of a current hospice resident's care.
DOCUMENT *Gap identification process review*	Reviews the process for identifying and closing coordination gaps between facility and hospice.

REFERENCES

[28] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require a written agreement between the facility and any hospice or palliative care service specifying which entity is responsible for each element of the resident's care.

Standard 6.3 · *Standard 6: End-of-Life & Palliative Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD6-v3.0

WHY THIS STANDARD EXISTS

When hospice care begins, two separate organizations become responsible for the same resident at the same time, and coordination gaps between them are a genuine, well-documented quality problem — a written agreement specifying who does what isn't bureaucratic formality, it's what actually prevents a resident falling through a gap between two providers who each assume the other is handling something.

The evidence: [28] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require a written agreement between the facility and any hospice or palliative care service specifying which entity is responsible for each element of the resident's care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, written agreement clearly defines responsibility for each service.	✗ Coordination relies on informal or assumed division of responsibility.
✓ Staff can confidently identify who is responsible for specific aspects of care.	✗ Staff are uncertain who is responsible for specific hospice resident care needs.
✓ A real process exists for identifying and closing coordination gaps.	✗ No process exists for identifying gaps before they result in a missed need.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **The written agreement is comprehensive but staff aren't fully familiar with its specific terms.**
An agreement that exists but isn't genuinely known by staff provides limited real coordination benefit.

2 **Responsibility is clear for medical care but less clear for personal care and daily support.**
Every category of care needs the same clear definition to prevent a genuine gap.

3 **A gap identification process exists but hasn't been genuinely tested with a real coordination issue.**
An untested process may not function smoothly when an actual gap needs to be caught and closed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current hospice coordination agreements for specific, comprehensive responsibility definitions.

Week 2 Brief staff thoroughly on the specific terms of the agreement.

Week 3 Establish a real process for identifying and closing coordination gaps.

Ongoing Review hospice coordination for any real gaps that emerge in practice.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual written agreement for a current or recent hospice resident.
A specific, real document is the evidence of genuine coordination, not an assumed arrangement.

Ask a staff member a specific question about who handles a particular need for a hospice resident.
A confident, specific answer reveals genuine clarity, not uncertainty papered over.

E-LEARNING academy.gmj.ge/ltc-std6-3-hospice-coordination — 30 min · complete before self-assessment

Standard 6.4 **NON-NEGOTIABLE** · *Standard 6: End-of-Life & Palliative Care*

Pain and Suffering Are Actively Anticipated and Treated, Not Just Responded To

ASSESSMENT ASF-LTC-STD6-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.4
NON-NEGOTIABLE
L1

THE STANDARD

Pain and Suffering Are Actively Anticipated and Treated, Not Just Responded To

A resident's pain and suffering — physical, emotional, social, spiritual — are actively anticipated and proactively addressed as part of ongoing care, not left until the resident reports significant distress, particularly for residents whose cognitive or communication impairment makes reporting pain genuinely difficult.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is pain and suffering actively, proactively assessed, not only addressed when a resident reports distress?** *Genuine, proactive assessment, not reliance on the resident to initiate a report.* Doc: Proactive pain assessment documentation	YES	PARTIAL	NO
2	**Is there a specific approach for assessing pain in residents whose cognitive or communication impairment makes self-reporting difficult?** *A specific, adapted assessment approach, not the same self-report method applied regardless of communication ability.* Doc: Non-verbal pain assessment tool	YES	PARTIAL	NO
3	**Does assessment genuinely cover emotional, social, and spiritual suffering, not physical pain alone?** *The full, genuine scope of suffering, not narrowed to physical symptoms.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Proactive assessment review*	Reviews documentation for genuine, scheduled proactive pain and suffering assessment.
DOCUMENT *Non-verbal assessment tool review*	Reviews the specific tool or approach used for residents with communication impairment.
OBSERVE *Scope observation*	Observes whether assessment genuinely covers emotional, social, and spiritual dimensions, not physical pain alone.

REFERENCES

[29] Established international clinical definitions of palliative care describe anticipating, preventing, and treating suffering as central to genuine palliative practice, distinct from reactive response to reported distress alone.

Standard 6.4 · *Standard 6: End-of-Life & Palliative Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD6-v3.0

WHY THIS STANDARD EXISTS

A resident who cannot easily communicate — due to cognitive impairment, illness, or the dying process itself — is at real risk of experiencing significant pain or suffering that goes unaddressed simply because it wasn't actively looked for, and waiting for a resident to report distress fails exactly the residents least able to do so.

The evidence: [29] Established international clinical definitions of palliative care describe anticipating, preventing, and treating suffering as central to genuine palliative practice, distinct from reactive response to reported distress alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Pain and suffering are proactively, genuinely assessed on a regular basis.	✗ Assessment happens only when a resident reports distress themselves.
✓ A specific, adapted assessment approach exists for residents with communication impairment.	✗ The same self-report method is used regardless of a resident's actual communication ability.
✓ Assessment genuinely covers the full range of suffering, not physical symptoms alone.	✗ Assessment is narrowed to physical pain, ignoring emotional, social, or spiritual suffering.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Proactive assessment happens for residents who can self-report but relies on observation alone for those who cannot, without a structured tool.**
A structured, validated approach for non-verbal residents provides more reliable identification than observation alone.

2 **Physical pain is proactively assessed but emotional and spiritual suffering are addressed only reactively.**
The full scope of suffering deserves the same proactive attention as physical pain specifically.

3 **A non-verbal assessment tool exists but isn't consistently used by all staff.**
Consistent use across all staff is what makes a structured tool genuinely reliable in practice.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current pain and suffering assessment practice for genuine proactive versus reactive approach.

Week 2 Establish or strengthen a structured, validated assessment tool for non-verbal residents.

Week 3 Expand assessment scope to genuinely cover emotional, social, and spiritual suffering.

Ongoing Audit assessment consistency across all staff and shifts.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask what specific tool is used to assess pain in a resident who cannot verbally communicate.
A specific, named tool reveals genuine, structured practice, not reliance on informal observation.

Ask how emotional or spiritual suffering is proactively identified, not just physical pain.
This tests whether the full scope of suffering is genuinely addressed.

E-LEARNING academy.gmj.ge/ltc-std6-4-proactive-suffering-assessment — 30 min · complete before self-assessment

Standard 6.5 **CORE** · *Standard 6: End-of-Life & Palliative Care*

Family Is Genuinely Included in End-of-Life Decisions, Not Just Informed

ASSESSMENT ASF-LTC-STD6-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

6.5
CORE
L1

THE STANDARD

Family Is Genuinely Included in End-of-Life Decisions, Not Just Informed

Family members are genuinely included as participants in end-of-life care decisions and planning conversations — not merely informed of decisions after they've already been made by clinical staff.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are family members genuinely included as participants in end-of-life decisions, not just informed afterward?** *Real, participatory inclusion, not notification of decisions already finalized.* Doc: Family participation documentation	YES	PARTIAL	NO
2	**Are family members given genuine opportunity to ask questions and express concerns before decisions are finalized?** *A real opportunity before finalization, not a decision presented as already settled.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Do families report feeling genuinely included, not just informed, in end-of-life decision-making?** *Real, reported experience of inclusion, not assumed from the process alone.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Family participation review*	Reviews documentation for genuine family participation in end-of-life planning, not just notification.
OBSERVE *Decision-making process observation*	Observes an actual or simulated end-of-life planning conversation for genuine family inclusion.
ASK *Family experience interview*	Asks a family member whether they felt genuinely included in decision-making, not just informed.

REFERENCES

[30] Genuine family participation in end-of-life care decision-making, distinct from notification of decisions already made, is established practice in palliative and end-of-life care literature for both improving decision quality and supporting family wellbeing through the experience.

Standard 6.5 · *Standard 6: End-of-Life & Palliative Care*

Guidance & Learning

GUIDANCE ASF-LTC-STD6-v3.0

WHY THIS STANDARD EXISTS

For most families, a resident's end-of-life period is one of the most significant experiences they'll share with that person, and genuine inclusion in decision-making — not just being told what's already been decided — matters both for making decisions that truly reflect the resident's wishes and for the family's own experience of this time.

The evidence: [30] Genuine family participation in end-of-life care decision-making, distinct from notification of decisions already made, is established practice in palliative and end-of-life care literature for both improving decision quality and supporting family wellbeing through the experience.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Family members are genuine, active participants in end-of-life decisions.	✗ Family members are informed of decisions after clinical staff have already finalized them.
✓ Families have real opportunity to ask questions and raise concerns before decisions are finalized.	✗ No real opportunity exists for family questions or concerns before finalization.
✓ Families report feeling genuinely included, not just informed.	✗ Families report feeling excluded or only nominally consulted.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Inclusion is genuine for major decisions but day-to-day comfort care adjustments aren't discussed with family.**
Ongoing comfort care decisions matter to families too, not only major turning points.

2 **Family is included when readily available but less consistently when family members live at a distance.**
Genuine inclusion shouldn't depend on a family member's physical proximity or availability.

3 **Conversations happen but families report feeling rushed rather than genuinely heard.**
The quality and pace of the conversation matters as much as whether it technically occurred.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current end-of-life decision-making practice for genuine family participation versus notification.

Week 2 Establish a process ensuring family opportunity to ask questions before decisions are finalized.

Week 3 Build accommodations for family members at a distance to genuinely participate.

Ongoing Gather family feedback on their genuine experience of inclusion in decision-making.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a family member directly whether they felt genuinely included, not just informed.
This tests lived experience, not process compliance alone.

Ask how a family member living at a distance would genuinely participate in a decision conversation.
This reveals whether inclusion is genuinely accessible, not dependent on physical presence.

E-LEARNING academy.gmj.ge/ltc-std6-5-family-inclusion — 30 min · complete before self-assessment

STANDARD 7

Governance & Staffing

MANDATORY

5 criteria

Standard 7.1 **NON-NEGOTIABLE** · *Standard 7: Governance & Staffing*

Staffing Levels Reflect Actual Resident Acuity, Not Just Headcount

ASSESSMENT ASF-LTC-STD7-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.1
NON-NEGOTIABLE
L1

THE STANDARD

Staffing Levels Reflect Actual Resident Acuity, Not Just Headcount

Nursing staffing levels are genuinely determined by the actual number, acuity, and diagnoses of current residents, based on a real facility assessment — not a fixed headcount applied regardless of how much the resident population's actual care needs have changed.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are staffing levels genuinely determined by actual resident acuity and diagnoses, not a fixed headcount alone?** *Real, acuity-based staffing determination, not a static number applied regardless of resident needs.* Doc: Facility assessment and staffing determination documentation	YES	PARTIAL	NO
2	**Is the facility assessment genuinely current, reflecting the actual present resident population?** *A real, current assessment, not one that's grown stale relative to the facility's actual residents.* Doc: Current facility assessment	YES	PARTIAL	NO
3	**When resident acuity increases, does staffing genuinely adjust, not remain fixed regardless of changing need?** *Real, responsive adjustment, not a static staffing level maintained regardless of actual need.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Facility assessment review*	Reviews the facility assessment for genuine currency and connection to actual staffing determination.
DOCUMENT *Staffing-acuity correlation review*	Reviews whether staffing levels genuinely correlate with documented resident acuity, not a fixed number.
ASK *Staffing adjustment interview*	Asks administration how staffing genuinely adjusts when resident acuity increases.

REFERENCES

[31] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require sufficient nursing staff determined by resident assessments, individual care plans, and the number, acuity, and diagnoses of the facility's actual resident population.

Standard 7.1 · *Standard 7: Governance & Staffing*

Guidance & Learning

GUIDANCE ASF-LTC-STD7-v3.0

WHY THIS STANDARD EXISTS

A fixed staffing number that doesn't account for how sick or dependent the current resident population actually is can look adequate on paper while genuinely failing residents whose real care needs have increased — the resident count alone tells you far less than resident acuity does about whether staffing is actually sufficient.

The evidence: [31] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require sufficient nursing staff determined by resident assessments, individual care plans, and the number, acuity, and diagnoses of the facility's actual resident population.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staffing levels genuinely reflect actual resident acuity and diagnoses.	✗ A fixed headcount is maintained regardless of actual resident acuity.
✓ The facility assessment is current and genuinely informs staffing.	✗ The facility assessment is outdated or disconnected from actual staffing decisions.
✓ Staffing responsively adjusts as resident acuity changes.	✗ Staffing remains static even as resident care needs genuinely increase.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **The facility assessment exists and is periodically updated but staffing decisions don't consistently reflect its findings.**
An assessment that doesn't genuinely inform staffing provides limited real protective value.

2 **Staffing adjusts for major acuity changes but not for the cumulative effect of smaller changes across the resident population.**
Gradual, cumulative acuity changes deserve the same genuine responsiveness as a single major change.

3 **Staffing is adequate for day shifts but less clearly matched to acuity for evening and overnight coverage.**
Resident acuity and care needs don't diminish outside daytime hours.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current facility assessment for genuine currency and connection to staffing.

Week 2 Establish a systematic process connecting acuity changes to staffing adjustment.

Week 3 Review staffing adequacy specifically across evening and overnight shifts.

Ongoing Update the facility assessment and staffing determination as the resident population genuinely changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask administration for a specific example of staffing adjusting in response to a genuine acuity increase.
A real, specific example reveals whether the connection between acuity and staffing is genuine, not just described in policy.

Check staffing levels specifically during evening and overnight shifts.
This is where staffing-to-acuity matching is most likely to show real gaps.

E-LEARNING academy.gmj.ge/ltc-std7-1-acuity-based-staffing — 30 min · complete before self-assessment

	Standard 7.2 **NON-NEGOTIABLE** · *Standard 7: Governance & Staffing* **Staffing Data Is Publicly Posted Daily and Genuinely Accurate**	**ASSESSMENT** ASF-LTC-STD7-v3.0

CR ADAPTED	**TR** FULL	**SM** FULL	**ST** FULL

7.2
NON-NEGOTIABLE
L1

THE STANDARD

Staffing Data Is Publicly Posted Daily and Genuinely Accurate

Daily nurse staffing information is posted publicly in the facility, genuinely reflecting actual hours worked by each category of staff, retained for the required period — not posted data that doesn't match what actually happened, or missing entirely.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is daily staffing information genuinely posted publicly, visible to residents, families, and visitors?** *Real, visible public posting, not data technically available but not genuinely accessible.* Doc: Daily staffing posting record	YES	PARTIAL	NO
2	**Does the posted data genuinely reflect actual hours worked, not planned or idealized staffing?** *Accurate, real data matching what actually happened, not a schedule that doesn't reflect reality.* Doc: Actual hours worked documentation	YES	PARTIAL	NO
3	**Is staffing data retained for at least 18 months, genuinely available on request?** *Real, complete retention, not gaps or missing historical data.* Doc: Staffing data retention record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Public posting check*	Physically verifies daily staffing information is genuinely posted and visible in the facility.
DOCUMENT *Accuracy verification review*	Cross-checks posted staffing data against actual timekeeping records for accuracy.
DOCUMENT *Retention record review*	Reviews staffing data retention for genuine 18-month completeness.

REFERENCES

[32] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require regular, genuinely accurate public reporting of nurse staffing information, including actual hours worked by each category of licensed and unlicensed nursing staff.

Standard 7.2 · *Standard 7: Governance & Staffing*

Guidance & Learning

GUIDANCE ASF-LTC-STD7-v3.0

WHY THIS STANDARD EXISTS

Publicly posted staffing data exists specifically so residents, families, and visitors can see the facility's actual staffing reality, not an idealized version — data that's inaccurate or simply not posted defeats the entire transparency purpose this requirement exists to serve.

The evidence: [32] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require regular, genuinely accurate public reporting of nurse staffing information, including actual hours worked by each category of licensed and unlicensed nursing staff.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Daily staffing information is genuinely, visibly posted publicly.	✗ Staffing information isn't posted, or is posted somewhere not genuinely visible to the public.
✓ Posted data accurately reflects actual hours worked, verified against real records.	✗ Posted data doesn't match actual hours worked.
✓ Staffing data is genuinely retained for at least 18 months.	✗ Retention has gaps or doesn't reach the required 18 months.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 Posting happens consistently but the location isn't genuinely visible or accessible to visitors.
A technically posted notice that's hard to find doesn't achieve genuine public transparency.

2 Data is generally accurate but occasional discrepancies exist between posted and actual hours.
Even occasional inaccuracy undermines the genuine reliability this transparency requirement is meant to provide.

3 Retention is maintained but not easily retrievable when specifically requested.
Data that's retained but difficult to access doesn't provide the practical transparency retention is meant to ensure.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current staffing posting location for genuine public visibility.

Week 2 Establish a verification process cross-checking posted data against actual timekeeping.

Week 3 Confirm staffing data retention meets the genuine 18-month requirement.

Ongoing Audit posted data accuracy against actual records periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Physically locate the posted staffing information as a visitor would.
This tests genuine visibility and accessibility, not just technical compliance.

Cross-check a specific day's posted data against actual timekeeping records.
A specific, real comparison reveals genuine accuracy, not assumed correctness.

E-LEARNING academy.gmj.ge/ltc-std7-2-staffing-transparency — 30 min · complete before self-assessment

Standard 7.3 **NON-NEGOTIABLE** · *Standard 7: Governance & Staffing*

A Data-Driven Quality Improvement Program Genuinely Drives Improvement, Not Just Documentation

ASSESSMENT ASF-LTC-STD7-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.3
NON-NEGOTIABLE
L1

THE STANDARD

A Data-Driven Quality Improvement Program Genuinely Drives Improvement, Not Just Documentation

The facility maintains an ongoing, data-driven quality assurance and performance improvement program that genuinely identifies and acts on real indicators of care and quality of life — including at least one annual improvement project targeting a genuine high-risk or problem-prone area — not a program that exists in documentation without producing genuine improvement.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the quality improvement program genuinely use real, current data to identify quality and safety indicators?** *Real data informing the program, not documentation disconnected from reality.* Doc: quality improvement data documentation	YES	PARTIAL	NO
2	**Is there at least one annual improvement project genuinely targeting a real high-risk area?** *A specific, genuine project, not a symbolic initiative.* Doc: Annual improvement project documentation	YES	PARTIAL	NO
3	**Is there real evidence the program has driven measurable improvement, not just documented activity?** *Actual, measurable improvement, not activity without demonstrated effect.* Doc: Improvement outcome evidence	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Data-driven practice review*	Reviews whether the quality improvement program genuinely uses real, current facility data.
DOCUMENT *Annual project review*	Reviews the annual improvement project for genuine focus on a real high-risk area.
DOCUMENT *Outcome evidence review*	Reviews evidence of genuine, measurable improvement resulting from quality improvement activity.

REFERENCES

[33] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require an effective, comprehensive, data-driven quality assurance and performance improvement program with documented evidence of systematic identification, investigation, and prevention of adverse events.

Standard 7.3 · *Standard 7: Governance & Staffing*

Guidance & Learning

GUIDANCE ASF-LTC-STD7-v3.0

WHY THIS STANDARD EXISTS

A quality improvement program that exists only as required paperwork, without genuinely using real data to identify and act on actual problems, provides none of the systematic improvement this requirement is meant to drive — the entire value of a data-driven approach depends on the data genuinely informing real action, not just being collected and filed.

The evidence: [33] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require an effective, comprehensive, data-driven quality assurance and performance improvement program with documented evidence of systematic identification, investigation, and prevention of adverse events.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The quality improvement program genuinely uses real, current data to identify indicators.	✗ The quality improvement program exists as documentation disconnected from actual facility data.
✓ The annual improvement project genuinely targets a real high-risk area.	✗ The annual project is symbolic or doesn't address a genuine high-risk area.
✓ Real evidence shows measurable improvement, not just documented activity.	✗ No real evidence connects quality improvement activity to measurable improvement.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Data collection is thorough but analysis doesn't consistently translate into genuine corrective action.**
Data without genuine action doesn't provide the real improvement this program is meant to drive.

2 **The annual project addresses a real area but scope doesn't match the facility's actual size and complexity.**
A project's scope should genuinely reflect the facility's own actual services and resources, not a generic template.

3 **Improvement is documented but not clearly measured against a specific, quantifiable baseline.**
Without a genuine, measurable baseline, it's difficult to confirm real improvement actually occurred.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current quality improvement program for genuine, data-driven practice versus documentation alone.

Week 2 Select or confirm an annual improvement project genuinely targeting a real high-risk area.

Week 3 Establish specific, measurable baselines for tracking genuine improvement.

Ongoing Review quality improvement outcomes against measurable baselines to confirm genuine improvement.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the specific, real data behind the current annual improvement project.
Real, specific data reveals whether the program is genuinely data-driven, not just documented as such.

Ask for measurable evidence that a past quality improvement project produced genuine improvement.
A real, measurable outcome distinguishes genuine improvement from activity recorded for compliance alone.

E-LEARNING academy.gmj.ge/ltc-std7-3-qapi-program — 30 min · complete before self-assessment

	Standard 7.4 **NON-NEGOTIABLE** · *Standard 7: Governance & Staffing* **Governance Sustains the Quality Improvement Program Through Leadership Transitions**	**ASSESSMENT** ASF-LTC-STD7-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.4
NON-NEGOTIABLE
L1

THE STANDARD

Governance Sustains the Quality Improvement Program Through Leadership Transitions

The facility's governing body holds genuine, documented accountability for the quality improvement program continuing through leadership and staffing transitions, with adequate resourcing — staff time, technical training — not a program that quietly weakens or lapses whenever key personnel change.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the governing body hold genuine, documented accountability for the quality improvement program?** *Real, institutional accountability, not dependence on one person's commitment.* Doc: Governing body accountability documentation	YES	PARTIAL	NO
2	**Has the program genuinely continued through a real leadership or staffing transition, without lapsing?** *Real, demonstrated continuity, not an assumption it would hold up.* Doc: quality improvement continuity record through transitions	YES	PARTIAL	NO
3	**Is the program adequately resourced, not left to function without real support?** *Genuine, adequate resourcing, not a program expected to run on goodwill alone.* Doc: quality improvement resourcing documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Governance accountability review*	Reviews documentation for genuine governing body accountability, not informal individual dependence.
DOCUMENT *Transition continuity review*	Reviews evidence that the quality improvement program genuinely continued through a real past leadership transition.
DOCUMENT *Resourcing review*	Reviews whether the program receives genuine, adequate resourcing.

REFERENCES

[34] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, establish that the governing body or executive leadership is responsible and accountable for ensuring a quality improvement program is sustained during transitions in leadership and staffing, and is adequately resourced.

Standard 7.4 · *Standard 7: Governance & Staffing*

Guidance & Learning

GUIDANCE ASF-LTC-STD7-v3.0

WHY THIS STANDARD EXISTS

A quality improvement program that depends entirely on one particular leader's personal commitment is genuinely fragile — real institutional accountability, held by the governing body itself rather than any single individual, is what allows a quality improvement program to survive leadership turnover without losing its actual substance.

The evidence: [34] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, establish that the governing body or executive leadership is responsible and accountable for ensuring a quality improvement program is sustained during transitions in leadership and staffing, and is adequately resourced.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The governing body holds genuine, documented institutional accountability.	✗ Accountability rests informally on one individual, not the governing body itself.
✓ The quality improvement program has genuinely continued through real leadership transitions.	✗ The program has weakened or lapsed during a past leadership transition.
✓ The program is adequately resourced with real staff time and training.	✗ The program lacks genuine, adequate resourcing to function.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Governing body accountability is documented but genuine engagement in practice is inconsistent.**
Documented accountability without genuine, active engagement provides limited real protection against program fragility.

2 **The program has weathered smaller staffing changes but hasn't yet been tested by a major leadership transition.**
Genuine resilience is best confirmed by how the program holds up under a real, significant transition, not assumed from smaller changes alone.

3 **Resourcing is generally adequate but technical training for quality improvement-specific skills is limited.**
Adequate resourcing includes the specific technical training quality improvement work genuinely requires, not just general staff time.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current quality improvement accountability structure for genuine governing body ownership.

Week 2 Establish documented processes ensuring program continuity through future transitions.

Week 3 Assess and strengthen resourcing, including quality improvement-specific technical training.

Ongoing Review program continuity and resourcing whenever a genuine leadership transition occurs.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the governing body directly about their own role in quality improvement accountability, not just administration.
A specific, confident answer from governance itself reveals genuine institutional ownership.

Ask about a real, past leadership transition and how the quality improvement program held up.
A real example reveals genuine resilience, not just an assumption the structure would hold.

E-LEARNING academy.gmj.ge/ltc-std7-4-governance-continuity — 30 min · complete before self-assessment

Standard 7.5 **NON-NEGOTIABLE** · *Standard 7: Governance & Staffing*

Staff Background Screening Prevents Hiring Anyone With a Documented Abuse Finding

ASSESSMENT ASF-LTC-STD7-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.5
NON-NEGOTIABLE
L1

THE STANDARD

Staff Background Screening Prevents Hiring Anyone With a Documented Abuse Finding

Every staff member is screened against relevant background checks and any national or regional care-worker registry before hire, with anyone found guilty of abuse, neglect, exploitation, or resident mistreatment genuinely excluded from employment — not a screening process that exists on paper but doesn't reliably catch a real, documented finding.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every staff member genuinely screened against relevant background checks and any national or regional care-worker registry before hire?** *Real, complete screening for every hire, not an inconsistent or partial process.* Doc: Pre-hire background screening record	YES	PARTIAL	NO
2	**Is anyone with a documented abuse, neglect, or mistreatment finding genuinely excluded from employment?** *A firm, reliable exclusion, not a screening process that misses real findings.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is screening genuinely repeated or rechecked periodically, not only performed once at initial hire?** *Ongoing, periodic verification, not a one-time check that could miss a finding entered later.* Doc: Periodic rescreening record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Pre-hire screening review*	Reviews background screening records for a sample of recent hires for genuine completeness.
DOCUMENT *Registry check verification*	Verifies actual registry checks were genuinely performed, not assumed.
DOCUMENT *Periodic rescreening review*	Reviews whether screening is genuinely repeated periodically after initial hire.

REFERENCES

[35] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit employing individuals with a documented, substantiated finding of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property, verified through the relevant national or regional screening mechanism.

Standard 7.5 · *Standard 7: Governance & Staffing*

Guidance & Learning

GUIDANCE ASF-LTC-STD7-v3.0

WHY THIS STANDARD EXISTS

A resident's safety depends fundamentally on the people caring for them not having a documented history of abuse or neglect, and a background screening process that's inconsistent or incomplete can allow exactly the risk this requirement exists to prevent to walk through the door.

The evidence: [35] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit employing individuals with a documented, substantiated finding of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property, verified through the relevant national or regional screening mechanism.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every staff member receives genuine, complete pre-hire background screening.	✗ Background screening is inconsistent or incomplete for some hires.
✓ Anyone with a documented abuse or mistreatment finding is reliably excluded.	✗ The screening process has gaps that could miss a documented finding.
✓ Screening is genuinely repeated periodically, not only at initial hire.	✗ Screening happens only once, never rechecked after initial hire.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Screening is thorough for direct care staff but less consistent for support or contracted staff.**
Anyone with resident access deserves the same genuine screening, regardless of their specific role.

2 **State registry checks are performed but not consistently documented as verified.**
Undocumented verification is difficult to distinguish from a check that wasn't genuinely completed.

3 **Initial screening is thorough but periodic rechecking isn't consistently performed.**
A finding entered after initial hire wouldn't be caught without genuine periodic rescreening.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current background screening practice for completeness across all staff roles, including contracted staff.

Week 2 Establish consistent, documented registry verification for every hire.

Week 3 Establish a periodic rescreening schedule beyond initial hire.

Ongoing Audit screening completeness and documentation for new hires.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual background screening documentation for a specific, recent hire.
A specific, real record is the genuine evidence of a functioning process, not an assumed one.

Ask specifically about screening practice for contracted or agency staff, not only direct employees.
This is where screening consistency most commonly shows real gaps.

E-LEARNING academy.gmj.ge/ltc-std7-5-abuse-prevention-screening — 30 min · complete before self-assessment

Endorsements

What follows are optional endorsements — additional standards layered on top of the base seven, never issued alone. A facility must genuinely pass Standards 1 through 7 before any endorsement below is assessed. "Long-Term Care Facility" alone means the base seven only. "Long-Term Care Facility + Medical Tourism" means the base seven, verified first, plus the endorsement that follows.

STANDARD 8

Medical Tourism

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

10 criteria

	Standard 8.1 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism* **Pricing Transparency for Ongoing International Placement**	**ASSESSMENT** ASF-LTC-STD8-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

8.1
NON-NEGOTIABLE
L1

THE STANDARD

Pricing Transparency for Ongoing International Placement

An international family receives a complete, written breakdown of ongoing monthly costs, included and excluded services, and any anticipated future cost changes tied to care level increases — before placement is finalized, not costs that emerge only after the resident has already moved in.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the family receive a complete, written breakdown of ongoing monthly costs before placement is finalized?** *Written and complete, covering the ongoing commitment, not a one-time figure.* Doc: Written ongoing cost breakdown	YES	PARTIAL	NO
2	**Are anticipated future cost changes tied to care level increases specifically disclosed in advance?** *Genuine advance disclosure of likely future changes, not costs that surprise the family later.* Doc: Future cost change disclosure	YES	PARTIAL	NO
3	**Is there a specific, transparent process for communicating any actual cost change once the resident is placed?** *A defined, transparent process, not an unexplained addition to the bill.* Doc: Cost change communication protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Ongoing cost disclosure review*	Reviews written cost breakdowns provided to international families for completeness and clarity on ongoing nature.
DOCUMENT *Future cost disclosure review*	Reviews whether anticipated care-level cost changes are specifically disclosed in advance.
ASK *Family cost experience interview*	Asks an international family whether ongoing costs have matched what they were told before placement.

REFERENCES

[36] WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force to an ongoing, long-term financial commitment arranged by a family with limited ability to reassess after placement.

Standard 8.1 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-LTC-STD8-v3.0

WHY THIS STANDARD EXISTS

Unlike a single procedure with a defined cost, long-term placement involves an ongoing financial commitment that can extend for years, and a family arranging this from abroad — often unable to easily visit and reassess — is in a genuinely poor position to notice or challenge unclear terms after the fact.

The evidence: [36] WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force to an ongoing, long-term financial commitment arranged by a family with limited ability to reassess after placement.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Families receive a complete, written breakdown of ongoing costs before placement.	✗ Cost disclosure is partial or given only after placement.
✓ Anticipated future cost changes are specifically disclosed in advance.	✗ Future cost changes tied to care level increases aren't disclosed in advance.
✓ A transparent process communicates any actual cost change.	✗ Cost increases appear without prior communication.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Base monthly costs are disclosed clearly but potential future care-level increases aren't specifically flagged.**
A family arranging placement from abroad benefits from knowing likely future costs, not only the current rate.

2 **Disclosure is written but not specifically confirmed as understood before the family commits.**
Distance and possible language barriers make active confirmation of understanding genuinely important here.

3 **Cost change notification exists but isn't adapted for a family in a different time zone.**
Genuine notification needs to actually reach a family who may not be immediately available.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current international placement cost disclosure for completeness and advance timing.

Week 2 Build a complete, written disclosure template covering ongoing costs and anticipated future changes.

Week 3 Establish a transparent, distance-appropriate cost change notification process.

Ongoing Audit actual costs against original disclosure for a sample of international placements.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask an international family directly whether ongoing costs have matched what they were told.
This is the clearest, most direct test of genuine pricing transparency over time.

Ask to see the actual written disclosure given to a specific, real family.
A real, specific document reveals whether disclosure genuinely happens, not just exists as policy.

E-LEARNING academy.gmj.ge/ltc-std8-1-ongoing-pricing-transparency — 30 min · complete before self-assessment

	Standard 8.2 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism* **Periodic Condition Updates Reach Family and Home-Country Physician**	**ASSESSMENT** ASF-LTC-STD8-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

8.2
NON-NEGOTIABLE
L1

THE STANDARD

Periodic Condition Updates Reach Family and Home-Country Physician

The resident's family and, where relevant, their home-country physician receive genuine, periodic updates on the resident's condition and care — not only at admission, and not only when a family member happens to ask.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the family receive genuine, periodic updates on the resident's condition, not only when they ask?** *Proactive, scheduled updates, not communication that depends entirely on the family initiating contact.* Doc: Periodic update record	YES	PARTIAL	NO
2	**Is a significant change in condition specifically communicated promptly, not folded into the next routine update?** *Prompt, specific communication for significant changes, not delayed until a scheduled check-in.* Doc: Significant change notification record	YES	PARTIAL	NO
3	**Where relevant, is the resident's home-country physician also kept genuinely informed?** *Real, ongoing physician communication, not contact limited to the family alone.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Periodic update record review*	Reviews records for genuine, proactive periodic updates to family, not reactive communication alone.
DOCUMENT *Significant change notification review*	Reviews whether significant condition changes are promptly communicated, not delayed.
ASK *Family communication interview*	Asks a family member how often they genuinely hear from the facility, and whether it's proactive.

REFERENCES

[37] Continuity of care and family engagement across international distance is identified in cross-border long-term care literature as requiring proactive, periodic communication, distinct from reactive updates provided only when specifically requested.

Standard 8.2 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-LTC-STD8-v3.0

WHY THIS STANDARD EXISTS

A family who placed a relative in long-term care abroad, often unable to visit easily or frequently, depends entirely on the facility proactively keeping them genuinely informed — waiting for the family to ask leaves long gaps where a real change in condition could go uncommunicated.

The evidence: [37] Continuity of care and family engagement across international distance is identified in cross-border long-term care literature as requiring proactive, periodic communication, distinct from reactive updates provided only when specifically requested.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Family receives genuine, proactive, periodic updates.	✗ Family hears from the facility only when they specifically ask.
✓ Significant changes are promptly communicated, not delayed to a scheduled check-in.	✗ Significant changes wait for the next routine update rather than prompt communication.
✓ Home-country physicians are kept genuinely informed where relevant.	✗ Home-country physicians receive no ongoing information.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 Updates happen periodically but the schedule isn't consistently maintained across all international residents.
Every international family deserves the same reliable, periodic communication.

2 Updates cover clinical status but not day-to-day quality of life or wellbeing.
A family separated by distance often values wellbeing information as much as clinical status.

3 Communication happens but isn't adapted for the family's time zone or preferred method.
Genuine communication needs to actually reach the family in a way that works for them.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current family communication practice for genuine, proactive periodic updates.

Week 2 Establish a defined update schedule and prompt significant-change notification process.

Week 3 Confirm communication methods are adapted to each family's time zone and preference.

Ongoing Audit update consistency for international families specifically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a family member when they last heard from the facility without having asked first.
This tests genuine proactive communication, not reactive response to family inquiry.

Ask how a significant condition change would actually reach the family, and how quickly.
A specific, confident answer reveals a genuine process, not an assumption.

E-LEARNING academy.gmj.ge/ltc-std8-2-periodic-family-updates — 30 min · complete before self-assessment

Standard 8.3 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism*

Language Access for the Resident and Visiting Family

ASSESSMENT ASF-LTC-STD8-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

8.3
NON-NEGOTIABLE
L1

THE STANDARD

Language Access for the Resident and Visiting Family

A genuinely competent interpreter is available for the resident's ongoing care conversations and for family members during visits — not an ad hoc arrangement using whichever staff member happens to speak some of the family's language.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is a genuinely competent interpreter available for the resident's ongoing care conversations, not only at admission?** *Real, ongoing interpreter access, not limited to a single initial conversation.* Doc: Interpreter access record	YES	PARTIAL	NO
2	**Is interpreter access specifically arranged for family visits, not improvised on the day?** *Planned in advance for scheduled visits, matched to the family's actual language.* Doc: Family visit interpreter arrangement record	YES	PARTIAL	NO
3	**Can the resident and family genuinely communicate about care decisions, not just exchange pleasantries?** *Genuine, substantive communication access, not superficial interaction alone.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Ongoing interpreter access review*	Reviews records for genuine, ongoing interpreter access beyond admission.
ASK *Family visit arrangement interview*	Asks staff how interpreter access is arranged in advance of a scheduled family visit.
OBSERVE *Communication quality observation*	Observes an interpreted interaction for genuine, substantive communication, not superficial exchange.

REFERENCES

[38] Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and clinical outcomes compared with ad hoc interpretation by untrained bilingual staff or family members.

Standard 8.3 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-LTC-STD8-v3.0

WHY THIS STANDARD EXISTS

Language access for an international long-term resident is an ongoing need, not a single admission-day requirement, and a family visiting from abroad — often for a limited, precious window of time — deserves genuine communication access during that visit, not improvised arrangements that leave real gaps in understanding.

The evidence: [38] Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and clinical outcomes compared with ad hoc interpretation by untrained bilingual staff or family members.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A competent interpreter is genuinely available for ongoing care conversations.	✗ Interpreter access exists only at admission, not for ongoing care.
✓ Interpreter access is specifically arranged in advance for family visits.	✗ Family visit interpretation is improvised, not planned in advance.
✓ Genuine, substantive communication about care decisions is possible.	✗ Communication is limited to superficial exchange, not genuine care discussion.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Interpreter access is reliable for scheduled care conferences but not for informal, spontaneous conversations.**
Meaningful communication can happen outside formally scheduled conversations too.

2 **Advance arrangement happens for planned visits but not for unplanned or shorter family visits.**
A shorter or less-planned visit still deserves the same genuine communication access.

3 **Interpretation is available but not consistently used for actual care decision discussions.**
The real value of interpreter access is in substantive care conversations, not routine interactions alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current interpreter access for genuine ongoing coverage, not admission-only.

Week 2 Establish advance-arranged interpreter access for scheduled family visits.

Week 3 Extend interpreter access to informal as well as formal care conversations.

Ongoing Confirm interpreter access for every planned family visit.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask about interpreter access for a family visit specifically, not just admission.
This is where access most commonly narrows relative to the initial conversation.

Observe an actual interpreted care conversation if a visit is occurring.
Direct observation reveals whether communication is genuinely substantive.

E-LEARNING academy.gmj.ge/ltc-std8-3-language-access — 30 min · complete before self-assessment

Standard 8.4 **CORE** · *Standard 8: Medical Tourism*

Family Visit Travel and Accommodation Coordination

ASSESSMENT ASF-LTC-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.4
CORE
L1

THE STANDARD

Family Visit Travel and Accommodation Coordination

The facility provides or coordinates genuine support for family members' travel and accommodation logistics when visiting from abroad — not leaving a family to navigate an unfamiliar country alone during what is often a limited, emotionally significant visit.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the facility provide or genuinely coordinate travel and accommodation support for visiting family?** *Real coordination, not information the family must act on entirely alone from abroad.* Doc: Family visit coordination documentation	YES	PARTIAL	NO
2	**Is accommodation genuinely convenient to the facility, supporting maximum time with the resident?** *Genuine proximity and convenience, not logistics that eat into limited visit time.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific point of contact for family logistics problems during their visit?** *A specific, known contact, not an assumption the family will manage independently.* Doc: Family logistics contact protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Coordination support review*	Reviews what genuine travel and accommodation coordination is provided to visiting families.
ASK *Accommodation convenience interview*	Asks a visiting family whether accommodation genuinely supported time with their relative.
DOCUMENT *Logistics contact review*	Reviews the specific point of contact provided for family logistics issues during a visit.

REFERENCES

[39] Patient and family-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction, a principle that applies with particular force to time-limited family visits.

Standard 8.4 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-LTC-STD8-v3.0

WHY THIS STANDARD EXISTS

A family visiting a relative in long-term care abroad often faces real logistical challenges — unfamiliar transit, language barriers, limited time — and genuine coordination support directly affects how much of a short, precious visit is actually spent with their relative rather than solving logistics.

The evidence: [39] Patient and family-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction, a principle that applies with particular force to time-limited family visits.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Genuine coordination support is provided for family visit logistics.	✗ Families receive only a generic list of options with no real coordination.
✓ Accommodation genuinely supports maximum time with the resident.	✗ Accommodation logistics consume significant time that could be spent with the resident.
✓ A specific logistics contact is available during the family's visit.	✗ No specific contact exists for family logistics problems during the visit.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Coordination support is offered for the arrival but not for return travel.**
Logistics support matters for the full visit, not only its beginning.

2 **Accommodation recommendations exist but aren't verified for genuine proximity and convenience.**
An unverified recommendation may not actually support maximum time with the resident.

3 **A contact exists but isn't clearly communicated to the family before their visit begins.**
A pathway the family doesn't know about provides no real function during the visit itself.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current family visit logistics support against genuine coordination versus informational lists.

Week 2 Verify accommodation recommendations for genuine proximity and convenience.

Week 3 Establish a specific, communicated logistics contact for family visits.

Ongoing Gather family feedback on visit logistics coordination quality.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a recent visiting family how logistics support actually worked in practice.
Real experience reveals more than a description of intended coordination.

Ask how much of a typical family visit is spent on logistics versus time with the resident.
This reveals whether coordination genuinely protects the value of a limited visit.

E-LEARNING academy.gmj.ge/ltc-std8-4-family-visit-coordination — 30 min · complete before self-assessment

Standard 8.5 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism*

Long-Term Residency and Legal Status Documentation Support

ASSESSMENT ASF-LTC-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.5
NON-NEGOTIABLE
L1

THE STANDARD

Long-Term Residency and Legal Status Documentation Support

The facility provides the specific documentation an international resident needs for their long-term residency or extended-stay legal status, correctly and promptly — not generic paperwork suited only to a short medical visa, applied to what is actually an ongoing, long-term placement.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the facility provide documentation specific to long-term residency or extended-stay status, not short-term medical visa paperwork?** *Documentation genuinely matched to the actual long-term nature of the placement.* Doc: Long-term residency documentation record	YES	PARTIAL	NO
2	**Is documentation provided with enough lead time for realistic long-term status processing?** *Genuine lead time reflecting the real processing timelines for extended-stay status.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific process for renewing or maintaining legal status over the course of an ongoing placement?** *A real, ongoing process, not documentation support limited to initial placement alone.* Doc: Status renewal support process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Documentation type review*	Reviews documentation provided for genuine match to long-term residency needs, not short-term visa templates.
ASK *Lead time interview*	Asks staff how far in advance long-term status documentation is typically provided.
DOCUMENT *Renewal support review*	Reviews the process for supporting legal status renewal over an ongoing placement.

REFERENCES

[40] Medical and long-term care travel facilitation literature identifies documentation delays and errors as a leading cause of placement disruption for international residents, with extended-stay legal status requiring genuinely distinct documentation from short-term medical visas.

Standard 8.5 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-LTC-STD8-v3.0

WHY THIS STANDARD EXISTS

Long-term residential care involves an extended, often indefinite stay, which carries genuinely different legal and immigration requirements than a short medical visit — documentation designed for a brief procedure-related visa doesn't meet the resident's actual, ongoing legal status needs.

The evidence: [40] Medical and long-term care travel facilitation literature identifies documentation delays and errors as a leading cause of placement disruption for international residents, with extended-stay legal status requiring genuinely distinct documentation from short-term medical visas.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Documentation is specifically matched to long-term residency needs.	✗ Documentation is generic, designed for short-term medical visits rather than long-term residency.
✓ Documentation is provided with realistic lead time for extended-stay processing.	✗ Documentation arrives too late for realistic long-term status processing.
✓ A real, ongoing renewal support process exists for the duration of placement.	✗ No process exists to support status renewal as the placement continues.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 Initial documentation is appropriate but renewal support isn't consistently offered as the placement continues.
Long-term status needs are ongoing, not resolved once at the start of placement.

2 Lead time is adequate for common cases but not for countries with longer extended-stay processing times.
Processing time varies significantly by country, and lead time should reflect the family's actual situation.

3 Documentation is accurate but the family isn't proactively reminded of renewal deadlines.
Proactive reminders help prevent a genuine lapse in legal status during an ongoing placement.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current documentation practice for genuine match to long-term residency needs.

Week 2 Establish country-specific extended-stay documentation checklists.

Week 3 Build a proactive renewal reminder and support process.

Ongoing Track legal status renewal timelines for international residents.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real example of long-term status documentation provided for a specific resident's country.
A real, specific example reveals genuine, correct matching to actual residency needs.

Ask how the facility tracks upcoming legal status renewal deadlines.
A specific, confident answer reveals a genuine, proactive process.

E-LEARNING academy.gmj.ge/ltc-std8-5-residency-documentation — 30 min · complete before self-assessment

	Standard 8.6 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism* **International Complaint and Redress Process**	**ASSESSMENT** ASF-LTC-STD8-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

8.6
NON-NEGOTIABLE
L1

THE STANDARD

International Complaint and Redress Process

International families have access to a genuine complaint and redress process reachable from their home country, with real evidence complaints are addressed — not a process that functionally only works for a family physically present in the country.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a specific complaint channel genuinely reachable from the family's home country?** *Genuine remote accessibility, not a channel that functionally only works locally.* Doc: Complaint channel documentation	YES	PARTIAL	NO
2	**Is the complaint channel accessible in relevant languages and adapted for time zone differences?** *Genuine accessibility accounting for real language and time zone barriers.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there real, documented evidence that complaints from international families are actually addressed?** *Genuine follow-through, not a channel that produces no real response.* Doc: Complaint resolution record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Complaint channel accessibility review*	Reviews whether the complaint channel is genuinely reachable and usable from abroad.
DOCUMENT *Language and time zone accessibility review*	Reviews whether the channel accounts for relevant languages and time zone differences.
DOCUMENT *Resolution record review*	Reviews documented evidence that complaints from international families are genuinely addressed.

REFERENCES

[41] Cross-border patient and family redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international families face.

Standard 8.6 · *Standard 8: Medical Tourism*

Guidance & Learning

GUIDANCE ASF-LTC-STD8-v3.0

WHY THIS STANDARD EXISTS

A family living abroad raising a concern about their relative's care faces real access barriers a locally-based family doesn't — language, time zone, unfamiliarity with the local system — and a complaint channel that doesn't genuinely accommodate this excludes exactly the families most likely to need it.

The evidence: [41] Cross-border patient and family redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international families face.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The complaint channel is genuinely reachable and usable from abroad.	✗ The complaint process functionally requires physical presence or local language fluency.
✓ The channel accounts for relevant languages and time zone differences.	✗ No accommodation exists for time zone or language barriers.
✓ Real, documented evidence shows complaints are genuinely addressed.	✗ No documented evidence exists that complaints from international families are addressed.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **A remote complaint channel exists but response times are significantly slower than for local complaints.**
A technically accessible channel that responds too slowly doesn't provide genuine redress.

2 **The channel is accessible by email but responses aren't genuinely timed to the family's time zone.**
Technical accessibility without genuine time zone awareness limits real, timely communication.

3 **Complaints are received but resolution isn't consistently communicated back to the family in a form they'd understand.**

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current complaint channel for genuine remote, language, and time zone accessibility.

Week 2 Establish or strengthen remote-accessible complaint intake in relevant languages.

Week 3 Establish documented resolution tracking with clear communication back to the family.

Ongoing Track response times and resolution rates for international family complaints specifically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real example of a complaint received from a family abroad.
A real example reveals whether the channel genuinely functions for exactly the families who need it most.

Test the complaint channel's accessibility in a language other than the local one.
This directly reveals genuine language accessibility, not an assumption of it.

E-LEARNING academy.gmj.ge/ltc-std8-6-complaint-redress — 30 min · complete before self-assessment

	Standard 8.7 NON-NEGOTIABLE · *Standard 8: Medical Tourism* **Placement Facilitator and Agent Verification**	ASSESSMENT ASF-LTC-STD8-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

8.7
NON-NEGOTIABLE
L1

THE STANDARD

Placement Facilitator and Agent Verification

Any placement facilitator or agent referring families to this facility is specifically verified — real business registration, a real, checkable track record — with the verification documented, not accepted based on the volume of placements they refer or how professional their marketing appears.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is each placement facilitator or agent specifically verified for legitimate business registration and a checkable track record?** *Genuine, specific verification, not accepted based on referral volume or marketing professionalism alone.* Doc: Facilitator verification record	YES	PARTIAL	NO
2	**Is verification documented and periodically reconfirmed, not done once and assumed to remain valid indefinitely?** *An active, periodically reconfirmed process, not a one-time check.* Doc: Periodic reconfirmation record	YES	PARTIAL	NO
3	**Is there a specific process for reviewing what a facilitator actually tells families about this facility?** *Active oversight of facilitator representations, not an assumption they accurately represent the facility.* Doc: Facilitator representation review process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Facilitator verification review*	Reviews verification records for business registration and track record for each facilitator.
DOCUMENT *Reconfirmation schedule review*	Reviews whether verification is periodically reconfirmed, not a one-time check.
ASK *Representation review interview*	Asks staff how they review what facilitators actually tell families about the facility.

REFERENCES

[42] Medical and long-term care placement governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the receiving facility itself.

Standard 8.7 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-LTC-STD8-v3.0

WHY THIS STANDARD EXISTS

A placement facilitator sits between the family and the facility with real influence over what the family is told and expects for a decision that will shape a relative's remaining years, and an unverified facilitator can misrepresent care quality, costs, or conditions in ways the facility only discovers after a family has already committed.

The evidence: [42] Medical and long-term care placement governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the receiving facility itself.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Each facilitator is specifically verified for legitimate registration and track record.	✗ Facilitators are accepted based on referral volume without specific verification.
✓ Verification is documented and periodically reconfirmed.	✗ Verification, if it happened, was never reconfirmed after initial acceptance.
✓ A specific process reviews what facilitators actually represent to families.	✗ No process exists to review what facilitators actually tell families.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Verification happens for new facilitator relationships but isn't reconfirmed for long-standing ones.**
A facilitator's legitimacy and practices can change over time even after an initial, valid verification.

2 **Verification covers business registration but not the accuracy of their family-facing representations.**
A legitimately registered facilitator can still misrepresent care quality or conditions to families.

3 **Families occasionally arrive with expectations that don't match what the facility actually offers.**
This is a real, observable signal that facilitator representation review deserves closer attention.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current facilitator relationships for specific verification versus assumed legitimacy.

Week 2 Establish or strengthen documented verification for every facilitator relationship.

Week 3 Build a periodic reconfirmation schedule and a process for reviewing facilitator representations.

Ongoing Review family expectations against facility reality as an indicator of facilitator accuracy.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual verification record for a specific, named facilitator.
A specific, documented record is the real evidence of genuine verification, not assumed legitimacy.

Ask a recent international family what they were told by their facilitator before placement.
This reveals whether facilitator representations actually match facility reality.

E-LEARNING academy.gmj.ge/ltc-std8-7-facilitator-verification — 30 min · complete before self-assessment

Standard 8.8 **NON-NEGOTIABLE** · *Standard 8: Medical Tourism*

Repatriation and End-of-Life Planning Across Borders Is Discussed in Advance

ASSESSMENT ASF-LTC-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.8
NON-NEGOTIABLE
L1

THE STANDARD

Repatriation and End-of-Life Planning Across Borders Is Discussed in Advance

For every international resident, the facility proactively discusses repatriation options and requirements with the family in advance — the documentation, timeline, and process required to return remains to the resident's home country, should death occur — not a conversation that first happens in the acute distress of an actual death.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the facility proactively discuss repatriation options with the family in advance, not only after a death occurs?** *A genuine, proactive conversation held calmly in advance, not first raised during acute grief.* Doc: Advance repatriation discussion record	YES	PARTIAL	NO
2	**Does the facility have genuine, current knowledge of the specific documentation and process required for this resident's home country?** *Specific, current, country-relevant knowledge, not generic awareness that repatriation exists.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific point of contact to support the family through the actual repatriation process, if needed?** *A real, known support contact, not an assumption the family will navigate this alone.* Doc: Repatriation support contact protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Advance discussion record review*	Reviews documentation of proactive repatriation conversations held with international families in advance.
ASK *Country-specific knowledge interview*	Asks staff about the specific repatriation requirements for a particular resident's home country.
DOCUMENT *Support contact review*	Reviews the specific point of contact available to support a family through repatriation if needed.

REFERENCES

[43] Established international consular practice recognizes that repatriation of remains across borders requires specific documentation, commonly including a mortuary or transit certificate and an authenticated local death certificate, coordinated between local authorities, the relevant embassy or consulate, and funeral directors in both countries.

Standard 8.8 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-LTC-STD8-v3.0

WHY THIS STANDARD EXISTS

Repatriating remains internationally is a genuinely complex, paperwork-heavy, and time-sensitive process, and a family who first learns this in the immediate aftermath of a death — while grieving, often from a different country and time zone — is in the worst possible position to navigate it well. Having this conversation calmly, in advance, is a genuine act of care for the family's future.

The evidence: [43] Established international consular practice recognizes that repatriation of remains across borders requires specific documentation, commonly including a mortuary or transit certificate and an authenticated local death certificate, coordinated between local authorities, the relevant embassy or consulate, and funeral directors in both countries.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Repatriation is proactively discussed with every international family in advance.	✗ Repatriation is first discussed only after a death has already occurred.
✓ Staff have specific, current knowledge of the relevant country's requirements.	✗ Staff have only generic awareness, without specific, current country knowledge.
✓ A specific support contact is available to help the family through the process.	✗ No specific support exists to help the family navigate the actual process.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **The conversation happens at admission but isn't revisited even after a significant health decline.**
A conversation held once, long before it may become relevant, may need genuine revisiting as circumstances change.

2 **General awareness of repatriation exists but specific requirements aren't confirmed for the resident's actual home country.**
Requirements genuinely vary by country, and generic awareness isn't the same as accurate, specific knowledge.

3 **A support contact exists but isn't clearly communicated to the family until it's actually needed.**
A family benefits from knowing this support exists before a crisis, not only in the moment.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for repatriation discussion timing — proactive versus reactive.

Week 2 Build country-specific repatriation information for common resident countries of origin.

Week 3 Establish and communicate a specific support contact for repatriation assistance.

Ongoing Revisit repatriation planning after any significant change in resident health status.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask whether repatriation has ever been discussed with a family before it became urgently relevant.
A real, proactive example reveals genuine practice, not reactive crisis response.

Ask staff what specific documents are required to repatriate remains to a particular country.
A specific, accurate answer reveals genuine, current knowledge, not generic awareness.

E-LEARNING academy.gmj.ge/ltc-std8-8-repatriation-planning — 30 min · complete before self-assessment

Standard 8.9 **CORE** · *Standard 8: Medical Tourism*

Cultural and Dietary Continuity for the International Resident

ASSESSMENT ASF-LTC-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.9
CORE
L1

THE STANDARD

Cultural and Dietary Continuity for the International Resident

An international resident's cultural, religious, and dietary practices from their country of origin are genuinely learned and accommodated on an ongoing basis — not assumed to be the same as, or expected to adapt to, the facility's local cultural default.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are the resident's own cultural, religious, and dietary practices from their country of origin genuinely learned?** *Specific, genuine effort to learn this resident's actual practices, not an assumption of local default.* Doc: Cultural and dietary preference documentation	YES	PARTIAL	NO
2	**Are these practices genuinely accommodated on an ongoing basis, not just noted at admission?** *Real, ongoing accommodation, not documentation without follow-through.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does the resident have any way to maintain connection to their own cultural community, not only facility-local culture?** *Genuine connection opportunity, not isolation from their own cultural background.* Doc: Cultural connection support documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Preference learning review*	Reviews evidence that the resident's own cultural and dietary practices were genuinely learned.
OBSERVE *Ongoing accommodation observation*	Observes whether documented preferences are genuinely reflected in daily practice.
DOCUMENT *Cultural connection review*	Reviews what genuine opportunity exists for the resident to maintain connection to their own cultural background.

REFERENCES

[44] Genuine accommodation of an international resident's own cultural, religious, and dietary practices, distinct from an assumption of adaptation to the facility's local default, is established practice in cross-cultural long-term care literature for supporting resident dignity and quality of life.

Standard 8.9 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-LTC-STD8-v3.0

WHY THIS STANDARD EXISTS

For a resident who has left their home country to live out their remaining years in a facility abroad, genuine cultural and dietary continuity isn't a minor comfort — it's a significant, ongoing part of dignity and quality of life for someone already navigating real distance from everything familiar.

The evidence: [44] Genuine accommodation of an international resident's own cultural, religious, and dietary practices, distinct from an assumption of adaptation to the facility's local default, is established practice in cross-cultural long-term care literature for supporting resident dignity and quality of life.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The resident's own cultural, religious, and dietary practices are genuinely learned.	✗ Practices are assumed to match the facility's local default without genuine inquiry.
✓ Practices are genuinely accommodated on an ongoing basis.	✗ Practices are noted at admission but not reflected in ongoing daily care.
✓ Genuine opportunity exists for cultural connection, not isolation.	✗ No opportunity exists for the resident to maintain cultural connection.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Dietary practices are accommodated but religious observance is less consistently supported.**
Genuine cultural continuity spans more than diet alone for most residents.

2 **Accommodation is strong initially but drifts toward facility-local default over time.**
Ongoing accommodation needs genuine, sustained attention, not only initial effort.

3 **Practices are respected individually but no broader opportunity exists to connect with others sharing this background.**
Individual accommodation and genuine community connection both contribute to real cultural continuity.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current cultural and dietary accommodation for genuine, specific learning versus assumed default.

Week 2 Establish ongoing accommodation practice reflecting the resident's actual, documented preferences.

Week 3 Explore opportunities for the resident to maintain connection to their own cultural background.

Ongoing Revisit cultural and dietary accommodation to confirm it hasn't drifted toward local default.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a resident or family member whether cultural and dietary practices genuinely feel respected.
This tests lived experience, not documentation alone.

Compare documented preferences against what's actually provided in daily practice.
This reveals whether accommodation is genuine and ongoing, not a one-time admission note.

E-LEARNING academy.gmj.ge/ltc-std8-9-cultural-continuity — 30 min · complete before self-assessment

Standard 8.10 **CORE** · *Standard 8: Medical Tourism*

Time Zone and Distance-Adapted Family Communication

ASSESSMENT ASF-LTC-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.10
CORE
L1

THE STANDARD

Time Zone and Distance-Adapted Family Communication

Communication with an international family — scheduled calls, video visits, updates — is genuinely adapted to their actual time zone and circumstances, not offered only during the facility's own local convenient hours regardless of what time it is for the family.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is scheduled family communication genuinely adapted to the family's actual time zone, not only the facility's convenient hours?** *Real, practical accommodation of the family's actual circumstances, not one-sided scheduling.* Doc: Time zone-adapted communication schedule	YES	PARTIAL	NO
2	**Are video visits or calls genuinely offered at times realistically workable for the family?** *Real, workable timing, not options that technically exist but are impractical for the family to use.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does the family report genuine satisfaction with their ability to stay connected, not describe it as a persistent struggle?** *Real, reported satisfaction, not communication that technically exists but functions poorly in practice.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Communication schedule review*	Reviews whether family communication scheduling genuinely accounts for time zone difference.
OBSERVE *Video visit timing observation*	Checks whether video visit options are genuinely offered at workable times for the family.
ASK *Family satisfaction interview*	Asks an international family about their genuine experience staying connected.

REFERENCES

[45] Distance and time zone adaptation in family communication, distinct from communication offered only at the facility's own local convenience, is established practice in international long-term care family engagement for maintaining genuine, sustainable connection.

Standard 8.10 · *Standard 8: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-LTC-STD8-v3.0

WHY THIS STANDARD EXISTS

A family separated by significant time difference faces a genuine, practical barrier to staying connected that a locally-based family doesn't, and communication offered only during the facility's own convenient hours can mean a family is regularly asked to choose between staying connected and reasonable sleep or work hours.

The evidence: [45] Distance and time zone adaptation in family communication, distinct from communication offered only at the facility's own local convenience, is established practice in international long-term care family engagement for maintaining genuine, sustainable connection.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Communication scheduling genuinely accounts for the family's actual time zone.	✗ Communication is offered only during the facility's own convenient local hours.
✓ Video visits and calls are offered at realistically workable times.	✗ Video visit timing is impractical for the family's actual time zone.
✓ Families report genuine satisfaction with staying connected.	✗ Families describe staying connected as a persistent, unresolved struggle.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Scheduling accommodates time zone for planned calls but not for spontaneous updates.**
Genuine accommodation benefits both planned and unplanned communication moments.

2 **Time zone adaptation happens for major care conferences but not for routine check-ins.**
Routine connection matters to a family too, not only major decision-point conversations.

3 **Options exist but aren't proactively offered, leaving the family to request accommodation themselves.**
Proactive accommodation is more genuinely supportive than requiring the family to ask for it each time.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current family communication scheduling for genuine time zone accommodation.

Week 2 Establish a standard practice of proactively offering time zone-appropriate options.

Week 3 Extend time zone accommodation to routine, not only major, communication.

Ongoing Gather family feedback on genuine satisfaction with staying connected.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask an international family directly whether communication timing genuinely works for them.
This tests lived experience, not scheduling policy alone.

Ask staff how they'd schedule a call with a family many time zones away.
A specific, thoughtful answer reveals genuine practice, not an assumption it's handled adequately.

E-LEARNING academy.gmj.ge/ltc-std8-10-distance-communication — 30 min · complete before self-assessment

STANDARD 9

Health & Migration

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

10 criteria

Standard 9.1 **NON-NEGOTIABLE** · *Standard 9: Health & Migration*

People-Centred Care Adapted to Migration and Displacement Experience

ASSESSMENT ASF-LTC-STD9-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

9.1
NON-NEGOTIABLE
L1

THE STANDARD

People-Centred Care Adapted to Migration and Displacement Experience

Care is genuinely adapted to a resident's migration and displacement experience — including trauma-informed practice, awareness of legal-status barriers to access, and support for continuity of care — not delivered identically regardless of that history.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is care genuinely adapted to a resident's migration and displacement experience, not delivered identically regardless of history?** *Genuine adaptation, not a generic cultural-awareness statement.* Doc: Training record on migration-adapted care	YES	PARTIAL	NO
2	**Is trauma-informed practice genuinely applied, not just referenced as a principle?** *Actual practice adaptation, not an assumption of general sensitivity.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are staff aware of legal-status barriers to access that may affect this specific resident?** *Specific awareness, not a general sense that barriers can exist.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

ASK *Migration-adapted care interview*	Asks staff how they adapt practice specifically for a resident's migration and displacement history.
OBSERVE *Trauma-informed practice observation*	Observes daily care for genuine trauma-informed practice, not generic sensitivity.
DOCUMENT *Training content review*	Reviews training materials for specific coverage of migration-adapted, trauma-informed care.

REFERENCES

[46] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

Standard 9.1 · *Standard 9: Health & Migration*
Guidance & Learning

GUIDANCE ASF-LTC-STD9-v3.0

WHY THIS STANDARD EXISTS

A refugee or migrant resident's health needs and vulnerabilities are shaped by what happened before they ever arrived at this facility — in their country of origin, in transit, and on arrival — and for a resident who will live here for years, care that ignores this context misses real, clinically relevant information and can retraumatise someone who has already experienced significant hardship.

The evidence: [46] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Care is genuinely, visibly adapted to migration and displacement history.	✗ Care is delivered identically regardless of migration history.
✓ Trauma-informed practice is actually applied, not just referenced.	✗ Trauma-informed practice exists only as a stated principle, not applied practice.
✓ Staff demonstrate specific awareness of legal-status access barriers.	✗ Staff show no specific awareness of legal-status barriers.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Adaptation happens for residents who disclose their history but isn't proactively considered otherwise.**
Not every resident will volunteer this history unprompted, even when it is clinically relevant.

2 **Staff are aware of the principle but haven't received specific training on applying it.**
General awareness doesn't reliably translate into genuine practice adaptation without specific training.

3 **Adaptation is strong at admission but isn't sustained as staff turn over during a resident's long-term stay.**
A years-long residency depends on this understanding genuinely persisting through staff changes, not fading over time.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine adaptation to migration and displacement history.

Week 2 Train staff specifically on trauma-informed, migration-adapted practice.

Week 3 Build awareness of legal-status access barriers into standard practice.

Ongoing Ensure new staff are briefed on a resident's migration history as part of onboarding to their care.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to describe a specific example of adapting care for a resident's migration history.
A real, specific example reveals genuine practice, not familiarity with the principle.

Ask a newer staff member how they learned about a specific resident's migration background.
This reveals whether this understanding genuinely persists through staff turnover.

E-LEARNING academy.gmj.ge/ltc-std9-1-migration-adapted-care — 30 min · complete before self-assessment

	Standard 9.2 NON-NEGOTIABLE · *Standard 9: Health & Migration* **Supporting Resident Agency Through Genuine Understanding of Care and the Facility**	ASSESSMENT ASF-LTC-STD9-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

9.2
NON-NEGOTIABLE
L1

THE STANDARD

Supporting Resident Agency Through Genuine Understanding of Care and the Facility

Residents are supported to genuinely understand both their own care and how to navigate the facility itself — with understanding actively verified through methods like teach-back, in plain language, not assumed from silence, a nod, or general goodwill information about the facility.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is understanding actively checked using a teach-back approach, for both the care plan and how the facility works, not assumed from a nod?** *Asking the resident to explain both back in their own words, not just asking "do you understand?"* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is concrete, practical guidance provided on navigating this facility specifically — daily routines, how to raise a concern, activities available?** *Real navigation guidance, not just general encouragement.* Doc: Navigation guidance material	YES	PARTIAL	NO
3	**Is information communicated in plain language, avoiding jargon, particularly when working through an interpreter?** *Complex terminology strains interpretation and comprehension together.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Teach-back practice observation*	Observes a care conversation, or a simulated scenario, to check whether teach-back genuinely verifies understanding of both care and facility navigation.
DOCUMENT *Navigation material review*	Reviews any materials or guidance provided on navigating the facility, in relevant languages.
ASK *Resident understanding check*	Asks a resident to explain back their care and how they would raise a concern or request something.

REFERENCES

[47] WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

Standard 9.2 · *Standard 9: Health & Migration*
Guidance & Learning

GUIDANCE ASF-LTC-STD9-v3.0

WHY THIS STANDARD EXISTS

For a refugee or migrant resident, understanding an unfamiliar long-term care facility and system can matter as much for genuine quality of life as any single care decision, and a resident who nods along without genuinely understanding — particularly through the added layer of interpretation — can live for years with a dangerously incomplete picture of their own care and rights.

The evidence: [47] WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Teach-back genuinely verifies understanding of both care and facility navigation.	✗ Understanding is assumed from a nod or silence, with no active verification.
✓ Concrete, translated navigation guidance is provided, not just general encouragement.	✗ Residents understand their specific care but not how to navigate the facility or raise concerns.
✓ Plain language is used consistently, especially when working through an interpreter.	✗ Jargon is used routinely, straining both interpretation and comprehension.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Teach-back is used for major care decisions but not extended to facility-navigation information.**
Understanding how to actually live within the facility matters as much as understanding the immediate care plan.

2 **Navigation support is given verbally at admission but not reinforced with anything the resident can review later.**
Complex facility information delivered once, verbally, under stress is easily forgotten, especially over a long residency.

3 **Staff assume understanding for residents who have lived at the facility longer, missing gaps that may still exist.**
Length of residency does not reliably correlate with genuine understanding.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current practice for both understanding-verification and facility-navigation support.

Week 2 Train staff on teach-back technique and develop translated navigation guidance.

Week 3 Brief staff to proactively cover facility navigation alongside the immediate care matter.

Ongoing Spot-check resident understanding of both care and navigation periodically throughout their stay.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual care conversation, watching specifically for teach-back covering both care and navigation.
This is a practice that is easy to describe in policy and easy to skip under time pressure.

Ask a longer-term resident directly what they understand about raising a concern.
This tests actual understanding sustained over time, not just satisfaction with an early conversation.

E-LEARNING academy.gmj.ge/ltc-std9-2-understanding-and-navigation — 30 min · complete before self-assessment

Standard 9.3 **NON-NEGOTIABLE** · *Standard 9: Health & Migration*

Language and Communication Aids — Interpreters and Cultural Mediators

ASSESSMENT ASF-LTC-STD9-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

9.3
NON-NEGOTIABLE
L1

THE STANDARD

Language and Communication Aids — Interpreters and Cultural Mediators

Trained interpreters or cultural mediators are engaged for language-discordant consultations and ongoing care conversations — never minor children, and only family members when genuinely no other option exists and the situation is not high-risk.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are trained interpreters or cultural mediators engaged for language-discordant consultations and ongoing care?** *Not ad hoc bilingual staff or family members as the default, and not limited to admission alone.* Doc: Interpreter engagement record	YES	PARTIAL	NO
2	**Is a minor ever used to facilitate interpretation for a family member?** *This should never happen — a specific, absolute rule, not a judgement call.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When a family member interprets due to genuine unavailability of a trained interpreter, is this reserved for low-risk situations only?** *Not used for informed consent, complex care, or bad news — situations WHO specifically flags as requiring professional language support.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Interpreter engagement review*	Reviews records for evidence of trained interpreter or cultural mediator engagement across the resident's ongoing care.
ASK *Minor-interpreter policy check*	Asks staff directly whether minors are ever used to interpret, and confirms understanding that this is never acceptable.
OBSERVE *High-risk situation check*	Checks whether family-member interpretation, where it occurs, is confined to genuinely low-risk situations, never consent or bad news.

REFERENCES

[48] WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

Standard 9.3 · *Standard 9: Health & Migration*

Guidance & Learning

GUIDANCE ASF-LTC-STD9-v3.0

WHY THIS STANDARD EXISTS

Family members interpreting, especially minors, carries real, well-documented risks — inaccurate interpretation, withheld or distorted information, compromised confidentiality, and trauma to the family member themselves. For a resident living here long-term, this isn't a single admission-day requirement but an ongoing need for the duration of their residency.

The evidence: [48] WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Trained interpreters or cultural mediators are the default for language-discordant care, ongoing not just at admission. ✓ Staff confirm, without hesitation, that minors are never used to interpret. ✓ Family-member interpretation, when it happens, is reserved for genuinely low-risk situations only.	✗ Ad hoc bilingual staff or family members are the default, with trained interpreters rarely engaged. ✗ A minor has been used to interpret, even occasionally. ✗ Family members interpret for high-risk situations like informed consent or bad news.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Trained interpreters are used at admission but family members fill in for routine, ongoing conversations.**
Ongoing care over a long residency carries the same real risk as the initial admission conversation.

2 **The no-minors rule is understood by senior staff but not consistently reinforced with newer or part-time staff.**
A critical safeguard needs to be embedded in onboarding, not assumed as common knowledge.

3 **Interpreter access exists during clinic hours but reverts to family members for urgent or after-hours situations.**
Coverage gaps at specific times undermine an otherwise sound policy.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent language-discordant care for interpreter engagement patterns across the full residency, not just admission.

Week 2 Establish or reinforce trained interpreter access, including for urgent and after-hours situations.

Week 3 Brief all staff explicitly and unambiguously that minors are never used to interpret.

Ongoing Audit family-member interpretation instances to confirm they're confined to genuinely low-risk situations.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the minor-interpreter question directly and expect an immediate, confident answer.
Any hesitation on this specific point is a serious signal worth investigating further.

Check interpreter coverage specifically for urgent or after-hours situations.
This is where the policy is most likely to quietly lapse.

E-LEARNING academy.gmj.ge/ltc-std9-3-language-cultural-mediators — 30 min · complete before self-assessment

Standard 9.4 **CORE** · *Standard 9: Health & Migration*

Collaborative Practice Across Health and Social Services

ASSESSMENT ASF-LTC-STD9-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

9.4
CORE
L1

THE STANDARD

Collaborative Practice Across Health and Social Services

The facility actively engages with legal, community, and social support services relevant to refugee and migrant residents, and conducts effective handover of care that includes migration- and displacement-related context — not treating residential care as isolated from these interconnected factors.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the facility actively engage with relevant legal and social support services, not treat care in isolation?** *Genuine, active engagement, not a general awareness that such services exist.* Doc: Social services engagement record	YES	PARTIAL	NO
2	**Does handover to another provider specifically include migration- and displacement-related context?** *Specific inclusion of this context, not a generic handover.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are staff aware of specific local services relevant to this population, not just services generally?** *Specific, current knowledge, not a vague sense that support services exist somewhere.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Social services engagement review*	Reviews evidence of active engagement with relevant social and legal support services.
DOCUMENT *Handover content review*	Reviews handover documentation for specific inclusion of migration-related context.
ASK *Local services knowledge interview*	Asks staff to name specific local services relevant to refugee and migrant residents.

REFERENCES

[49] WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

Standard 9.4 · *Standard 9: Health & Migration*

Guidance & Learning

GUIDANCE ASF-LTC-STD9-v3.0

WHY THIS STANDARD EXISTS

Legal status, community connection, and social support don't just sit alongside a refugee or migrant resident's wellbeing — they actively shape it, and a facility that treats care in isolation from these factors, or that fails to hand over migration-related context to another provider, misses information a purely clinical view wouldn't capture.

The evidence: [49] WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The facility actively, genuinely engages with relevant legal and social support services.	✗ Care is treated in isolation from legal and social support factors.
✓ Handover to other providers specifically includes migration-related context.	✗ Handover is generic, omitting migration-related context.
✓ Staff can name specific, current local services relevant to this population.	✗ Staff have no specific knowledge of relevant local services.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Engagement happens with legal services but not consistently with broader community support.**
Each of these factors can independently and significantly affect a resident's wellbeing.

2 **Handover includes clinical information but omits migration-related context that shaped the resident's care.**

3 **Staff know general categories of support exist but not specific, current local contacts.**
Specific, current knowledge is what makes a referral actually actionable.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Map current engagement with relevant legal and social support services.

Week 2 Establish or strengthen specific, current local service contacts.

Week 3 Build migration-related context into standard handover documentation.

Ongoing Refresh knowledge of local services periodically as availability changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to name a specific local service they would refer a resident's family to, not a general category.
Specificity reveals genuine, current knowledge rather than assumed awareness.

Review a real handover document for migration-related context inclusion.
A real example reveals whether this happens in practice, not just in policy.

E-LEARNING academy.gmj.ge/ltc-std9-4-collaborative-practice — 30 min · complete before self-assessment

Standard 9.5 **NON-NEGOTIABLE** · *Standard 9: Health & Migration*

Trauma Resurfacing With Cognitive Decline Is Recognised and Addressed

ASSESSMENT ASF-LTC-STD9-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

9.5
NON-NEGOTIABLE
L1

THE STANDARD

Trauma Resurfacing With Cognitive Decline Is Recognised and Addressed

Staff are trained to recognise that the onset or progression of dementia can trigger the re-emergence of traumatic stress symptoms dormant for decades — particularly among refugee and displaced residents — with a resident's known life history actively used to understand and respond to these symptoms, not treated as unrelated behavioral decline.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are staff trained that dementia can trigger re-emergence of dormant trauma symptoms, particularly for refugees?** *Specific training on this phenomenon, not general dementia training alone.* Doc: Trauma-dementia training record	YES	PARTIAL	NO
2	**Is a resident's known trauma history actively used to understand specific symptoms or triggers?** *Genuine application of known history, not care disconnected from it.* Doc: Life history and trauma-informed care plan	YES	PARTIAL	NO
3	**Are care practices — bathing, personal care, restricted movement — reviewed for retraumatising potential?** *Specific, individual review, not a generic assumption.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Training review*	Reviews training content for specific coverage of trauma re-emergence in dementia, distinct from general dementia training.
DOCUMENT *Life history application review*	Reviews whether known trauma history genuinely informs a resident's individual care plan and response to symptoms.
ASK *Care practice review interview*	Asks staff whether standard care practices have been specifically reviewed for retraumatising potential for a resident with known trauma history.

REFERENCES

[50] Nygren B, Hydén LC. Caring for older people with dementia reliving past trauma. Nurs Ethics. 2020;27(2):621-633 — documents that the onset of dementia can trigger the re-emergence of traumatic stress symptoms dormant for decades among genocide and violence survivors, and establishes that knowledge of a resident's life story enables staff to adapt care and avoid retraumatising triggers.

Standard 9.5 · *Standard 9: Health & Migration*
Guidance & Learning

GUIDANCE ASF-LTC-STD9-v3.0

WHY THIS STANDARD EXISTS

For a refugee resident who survived violence, displacement, or genocide, dementia can genuinely bring long-dormant trauma back to the surface — a documented phenomenon distinct from typical dementia-related behavioral change — and staff who don't recognise this risk responding to a genuine trauma re-emergence as if it were simply confusion or aggression, missing what the resident is actually experiencing.

The evidence: [50] Nygren B, Hydén LC. Caring for older people with dementia reliving past trauma. Nurs Ethics. 2020;27(2):621-633 — documents that the onset of dementia can trigger the re-emergence of traumatic stress symptoms dormant for decades among genocide and violence survivors, and establishes that knowledge of a resident's life story enables staff to adapt care and avoid retraumatising triggers.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff are specifically trained on trauma re-emergence in dementia, not general behavior training alone.	✗ Trauma re-emergence is not distinguished from general dementia-related behavioral change.
✓ Known trauma history and life story genuinely inform individual care response.	✗ Known history isn't connected to actual care planning or symptom response.
✓ Standard care practices are specifically reviewed for retraumatising potential for residents with known trauma history.	✗ Standard care practices are applied uniformly without considering individual retraumatising risk.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Staff recognise the general concept but don't consistently apply it to specific behavioral episodes.**
General awareness needs to translate into genuine, individual application during real moments of distress.

2 **Life history is documented but not actively referenced during care planning or in-the-moment response.**
Documented history that isn't genuinely used provides limited real protective value.

3 **Awareness is strong among nursing staff but not consistently shared with support staff providing daily personal care.**
Personal care moments are often exactly where retraumatising triggers occur, and support staff need the same awareness.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current staff awareness of trauma re-emergence as distinct from general dementia behavior.

Week 2 Train staff specifically on this documented phenomenon and how life history informs response.

Week 3 Review standard care practices for individual retraumatising potential for residents with known trauma history.

Ongoing Revisit trauma-informed care planning as a resident's dementia progresses.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to describe a specific example of connecting a resident's life history to a behavioral episode.
A real, specific example reveals genuine understanding, not familiarity with the general concept.

Ask how personal care practices, like bathing assistance, have been adapted for a resident with known trauma history.
This tests whether the principle translates into genuine, practical care adaptation.

E-LEARNING academy.gmj.ge/ltc-std9-5-trauma-dementia-intersection — 30 min · complete before self-assessment

Standard 9.6 **CORE** · *Standard 9: Health & Migration*

Evidence-Informed Care for Refugee and Migrant Elderly Residents

ASSESSMENT ASF-LTC-STD9-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

9.6
CORE
L1

THE STANDARD

Evidence-Informed Care for Refugee and Migrant Elderly Residents

Staff use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general elderly population, and identify where evidence gaps remain — not applying general geriatric guidelines uncritically to a population with documented, different health needs and risk factors.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are staff aware of evidence-informed guidelines specific to refugee and migrant health where they exist?** *Specific, current awareness, not general geriatric knowledge assumed to be sufficient.* Doc: Guideline awareness record	YES	PARTIAL	NO
2	**Do staff recognise where this population's health needs genuinely differ from the general elderly population?** *Genuine, specific recognition — for example, elevated PTSD and chronic disease risk — not an assumption that general guidelines always apply equally.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is practice adapted where population-specific evidence indicates a different approach is warranted?** *Actual practice adaptation, not awareness without application.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Guideline awareness review*	Reviews whether staff have access to and awareness of population-specific evidence-informed guidelines.
ASK *Population-difference interview*	Asks staff to describe a specific way this population's health needs differ from the general elderly population.
OBSERVE *Practice adaptation check*	Checks whether practice genuinely reflects population-specific evidence where it exists.

REFERENCES

[51] WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

Standard 9.6 · *Standard 9: Health & Migration*

Guidance & Learning

GUIDANCE ASF-LTC-STD9-v3.0

WHY THIS STANDARD EXISTS

Refugee and migrant elders carry a genuinely different risk profile than the general elderly population — elevated rates of uncontrolled chronic conditions, PTSD, and depression, all independently linked to cognitive decline — and care that ignores this and applies general geriatric guidelines uncritically can miss real, evidence-based adjustments this specific population needs.

The evidence: [51] WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff are aware of and use population-specific evidence-informed guidelines where they exist.	✗ General geriatric guidelines are applied uncritically with no population-specific awareness.
✓ Staff can describe specific, genuine differences in this population's health needs.	✗ Staff cannot describe any specific way this population's needs differ.
✓ Practice is genuinely adapted where population-specific evidence indicates it should be.	✗ Awareness exists but doesn't translate into any actual practice adaptation.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Awareness exists for well-known differences but not for more specific or recent evidence.**
Evidence in this area continues to develop, and awareness needs to stay genuinely current.

2 **Guidelines are known but not consistently applied under time pressure.**
Consistent application under real conditions is what gives awareness genuine protective value.

3 **Evidence gaps are acknowledged but staff default to general population assumptions rather than flagging genuine uncertainty.**
Recognising a genuine gap honestly is different from silently defaulting to a possibly inapplicable assumption.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current awareness of population-specific evidence-informed guidelines.

Week 2 Establish access to current, relevant guidelines for staff.

Week 3 Train staff on specific, genuine population differences relevant to practice.

Ongoing Refresh awareness as evidence in this area develops.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff for a specific example of a practice adaptation based on population-specific evidence.
A real example reveals genuine application, not just familiarity with the concept.

Ask how staff would handle a genuine evidence gap for this population.
A thoughtful, honest answer reveals genuine engagement rather than a default assumption.

E-LEARNING academy.gmj.ge/ltc-std9-6-evidence-informed-care — 30 min · complete before self-assessment

Standard 9.7 **NON-NEGOTIABLE** · *Standard 9: Health & Migration*

Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

ASSESSMENT ASF-LTC-STD9-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

9.7
NON-NEGOTIABLE
L1

THE STANDARD

Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

Staff maintain active awareness of their own culture, beliefs, and potential biases through structured reflective practice, and the facility actively fosters a supportive environment with genuine access to psychological support — not assumed self-awareness or an assumption that staff will manage vicarious trauma exposure on their own.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the facility have a structured process for staff reflective practice regarding bias and cultural awareness?** *A defined process, not an assumption that staff will naturally self-reflect adequately.* Doc: Reflective practice process description	YES	PARTIAL	NO
2	**Does the facility provide genuine, accessible psychological support for staff working with residents who have severe trauma histories?** *Actual, used support, not a theoretical benefit or informal hope.* Doc: Psychological support access record	YES	PARTIAL	NO
3	**Can staff describe a specific instance of adapting their practice after recognising a bias, and do they recognise signs of vicarious trauma in themselves or colleagues?** *Genuine, concrete examples, not general statements of good intentions or awareness.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Reflective practice process review*	Reviews the facility's structured process, if any, for staff reflective practice on bias and cultural awareness.
DOCUMENT *Support access review*	Reviews what psychological support genuinely exists and whether staff actually use it.
ASK *Staff example interview*	Asks a staff member for a specific instance of recognising and adapting for their own bias, and how they process the emotional weight of this work.

REFERENCES

[52] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

Standard 9.7 · *Standard 9: Health & Migration*

Guidance & Learning

GUIDANCE ASF-LTC-STD9-v3.0

WHY THIS STANDARD EXISTS

Unacknowledged bias shapes care judgement in ways that are genuinely hard to see from the inside, and staff providing long-term, intimate care to residents with severe trauma histories are regularly exposed to real, accumulating emotional weight — both require structured, deliberate support rather than being left to individual capacity alone.

The evidence: [52] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A structured reflective practice process genuinely exists and is used, not just assumed.	✗ No structured reflective practice process exists beyond an assumption of individual self-awareness.
✓ Genuine, accessible psychological support exists and staff actually use it.	✗ Psychological support exists only nominally, with no evidence staff actually access it.
✓ Staff can describe specific, real examples of both bias adaptation and vicarious trauma awareness.	✗ Staff cannot describe any specific example of adapting practice or recognising vicarious trauma.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Reflective practice happens informally among some staff but is not structured or facility-wide.**
Individual good practice does not reliably generalise without a defined, shared process.

2 **Support exists but staff are unaware it is available or feel discouraged from using it.**
A benefit's existence does not guarantee genuine, comfortable access to it.

3 **Support exists for acute incidents but not for the cumulative emotional weight of long-term care for trauma survivors.**
This is ongoing, long-term work, and cumulative emotional impact deserves the same genuine support as acute incidents.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current training content and support access for genuine coverage of bias and staff wellbeing.

Week 2 Establish a structured reflective practice process and strengthen support access.

Week 3 Deliver specific training on institutional discrimination and normalise use of available psychological support.

Ongoing Revisit reflective practice and staff wellbeing periodically, using real case examples where appropriate.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a specific personal example, not a general statement of awareness.
A concrete instance distinguishes genuine reflective practice from familiarity with the concept.

Ask staff directly whether they have used available support, not just whether it exists.
Genuine uptake, not nominal availability, is the real test.

E-LEARNING academy.gmj.ge/ltc-std9-7-reflective-practice-and-self-care — 30 min · complete before self-assessment

Standard 9.8 **CORE** · *Standard 9: Health & Migration*

Legal Status Diversity Recognition

ASSESSMENT ASF-LTC-STD9-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

9.8
CORE
L1

THE STANDARD

Legal Status Diversity Recognition

The facility can name which legal status categories it actually serves — asylum seeker, recognised refugee, stateless person, and others — and demonstrates it doesn't apply a single, uniform assumption about access rights and future planning across all of them.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Can staff name the specific legal status categories this facility actually serves?** *Specific, named categories, not a general sense that "migrants" are served.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Does the facility avoid applying a single, uniform assumption about access rights and future planning across all statuses?** *Genuine differentiation, not treating all categories identically.* Doc: Status-specific care and planning policy documentation	YES	PARTIAL	NO
3	**Is there a specific process for verifying which category applies when it's genuinely unclear?** *A real, defined process, not guesswork or assumption when status is ambiguous.* Doc: Status verification process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

ASK *Status category awareness interview*	Asks staff to name the specific legal status categories this facility actually serves.
DOCUMENT *Status-specific policy review*	Reviews documentation for genuine differentiation across status categories, not a uniform assumption.
DOCUMENT *Verification process review*	Reviews the process for verifying status when it's genuinely unclear.

REFERENCES

[53] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

Standard 9.8 · *Standard 9: Health & Migration*

Guidance & Learning

GUIDANCE ASF-LTC-STD9-v3.0

WHY THIS STANDARD EXISTS

Asylum seeker, recognised refugee, and stateless person are not interchangeable categories — they carry genuinely different legal rights and, for a long-term resident, genuinely different implications for future planning, including where end-of-life documentation and decisions will ultimately be recognised.

The evidence: [53] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff can name the specific legal status categories this facility actually serves.	✗ Staff have only a general sense that "migrants" are served, without specific categories.
✓ Policy genuinely differentiates access and planning considerations across status categories.	✗ A single, uniform assumption about access rights and planning is applied regardless of status.
✓ A specific, defined process exists for verifying unclear status.	✗ No process exists for verifying status when it's genuinely unclear.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **Staff can name the most common category served but not less frequent ones the facility still encounters.**
Even infrequent categories deserve genuine, specific awareness, not the risk of misapplied assumptions.

2 **Differentiation exists in policy but isn't consistently applied by all staff in practice.**
A policy that exists on paper needs consistent application to provide real protection.

3 **Status is understood for care access but not connected to longer-term planning implications.**
Legal status can genuinely affect future planning, not only immediate access to care.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current staff awareness of the specific legal status categories actually served.

Week 2 Build specific, differentiated guidance for each relevant status category, including planning implications.

Week 3 Establish a clear verification process for genuinely unclear status.

Ongoing Refresh staff awareness periodically, particularly for less frequently encountered categories.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to name every specific legal status category the facility has served recently.
Specificity reveals genuine, current awareness rather than a general assumption.

Ask what happens when a resident's specific status is genuinely unclear.
A confident, specific answer reveals a genuine process, not improvisation.

E-LEARNING academy.gmj.ge/ltc-std9-8-legal-status-recognition — 30 min · complete before self-assessment

Standard 9.9 **NON-NEGOTIABLE** · *Standard 9: Health & Migration*

End-of-Life Planning Honours the Resident's Culture When Return Home Isn't Possible

ASSESSMENT ASF-LTC-STD9-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

9.9
NON-NEGOTIABLE
L1

THE STANDARD

End-of-Life Planning Honours the Resident's Culture When Return Home Isn't Possible

For a refugee or stateless resident who cannot return to their country of origin, even in death, end-of-life planning genuinely explores culturally and religiously appropriate alternatives — a local ceremony reflecting their tradition, connection with a diaspora community — not a default assumption that standard local practice is the only available option.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does end-of-life planning genuinely explore culturally and religiously appropriate alternatives for a resident who cannot return home?** *Real, proactive exploration of meaningful alternatives, not silence or a default assumption.* Doc: Culturally adapted end-of-life planning documentation	YES	PARTIAL	NO
2	**Is there genuine effort to connect the resident with a relevant diaspora or faith community, where one exists?** *Real, active effort, not an assumption none exists or that it isn't the facility's role to help find one.* Doc: Community connection effort documentation	YES	PARTIAL	NO
3	**Is this conversation held with genuine sensitivity to why return isn't possible, not treated as a routine, generic discussion?** *Genuine sensitivity to the resident's specific, often painful situation, not a generic planning conversation.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Culturally adapted planning review*	Reviews end-of-life planning documentation for genuine exploration of appropriate alternatives.
DOCUMENT *Community connection review*	Reviews evidence of genuine effort to connect the resident with relevant diaspora or faith community.
ASK *Conversation sensitivity interview*	Asks staff how they approach this conversation with genuine sensitivity to the resident's situation.

REFERENCES

[54] Genuine exploration of culturally and religiously appropriate end-of-life alternatives for residents unable to return to their country of origin, distinct from default application of local custom, is established practice in refugee and displaced-population end-of-life care literature.

Standard 9.9 · *Standard 9: Health & Migration*

Guidance & Learning

GUIDANCE ASF-LTC-STD9-v3.0

WHY THIS STANDARD EXISTS

For many refugees, the country they fled is not a place they can return to even after death — due to ongoing conflict, statelessness, or the same danger that caused their displacement in the first place — and a resident facing this reality deserves a genuine, proactive conversation about meaningful alternatives, not silence on a painful reality or a default to unfamiliar local custom.

The evidence: [54] Genuine exploration of culturally and religiously appropriate end-of-life alternatives for residents unable to return to their country of origin, distinct from default application of local custom, is established practice in refugee and displaced-population end-of-life care literature.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ End-of-life planning genuinely explores meaningful, culturally appropriate alternatives.	✗ No alternative is explored beyond default local custom.
✓ Genuine effort connects the resident with relevant diaspora or faith community where one exists.	✗ No effort is made to identify or connect with a relevant diaspora or faith community.
✓ The conversation is held with genuine sensitivity to the resident's specific situation.	✗ The conversation is generic, not adapted to the resident's specific, painful reality.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **The conversation happens but relies on the resident to raise it themselves rather than being proactively offered.**
A resident may not know to ask, or may find it too painful to raise unprompted, without the facility proactively offering the conversation.

2 **Community connection is attempted but not genuinely pursued if initial contact doesn't succeed.**
A meaningful connection may take real, sustained effort to establish, not a single attempted contact.

3 **Planning happens for the resident but doesn't specifically involve family members who may also be displaced across multiple countries.**
Family involvement in this planning may itself require genuine cross-border coordination for a displaced family.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current end-of-life planning practice for residents unable to return to their country of origin.

Week 2 Build genuine, proactive practice for exploring culturally appropriate alternatives.

Week 3 Establish a genuine effort process for connecting with relevant diaspora or faith communities.

Ongoing Revisit this planning as a resident's circumstances or wishes may change.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff for a real, specific example of this conversation and what alternatives were genuinely explored.
A real example reveals whether this is genuine practice, not just policy language.

Ask how the facility would help connect a resident with a relevant community if none is already known.
A specific, thoughtful answer reveals genuine, active effort, not passive assumption.

E-LEARNING academy.gmj.ge/ltc-std9-9-end-of-life-cultural-alternatives — 30 min · complete before self-assessment

	Standard 9.10 NON-NEGOTIABLE · *Standard 9: Health & Migration* **Care Is Documented and Provided Regardless of Immigration or Legal Status**	ASSESSMENT ASF-LTC-STD9-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

9.10
NON-NEGOTIABLE
L1

THE STANDARD

Care Is Documented and Provided Regardless of Immigration or Legal Status

Care is provided and fully documented for every resident regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to residents without documented status.

FACILITY SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is the same standard of care applied and documented the same way regardless of a resident's immigration or legal status?** *Genuinely equal treatment, not a lesser or informal standard for undocumented residents.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation?** *Specific, documented training, not assumed understanding.* Doc: Staff training record	YES	PARTIAL	NO
3	**Is resident information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information?** *The same confidentiality protection extended to every resident, without exception.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Care standard observation*	Observes whether care and documentation practice is genuinely consistent regardless of resident status.
DOCUMENT *Staff training review*	Reviews training records confirming staff understand immigration status is never a basis for differential care.
ASK *Confidentiality practice interview*	Asks staff how resident status information, where known, is protected.

REFERENCES

[55] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

Standard 9.10 · *Standard 9: Health & Migration*

Guidance & Learning

GUIDANCE ASF-LTC-STD9-v3.0

WHY THIS STANDARD EXISTS

A family placing a relative who fears that seeking care will expose immigration status to consequences may delay or avoid care entirely, and any indication that this facility applies a different standard based on status only reinforces that fear — genuine equal treatment, documented the same way for everyone, is what makes long-term care genuinely accessible to this population.

The evidence: [55] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Care and documentation are genuinely consistent regardless of status.	✗ Care or documentation practice differs based on a resident's known or assumed status.
✓ Staff are specifically trained on this principle, not assumed to understand it.	✗ No specific training addresses this principle.
✓ Confidentiality protection is applied equally without exception.	✗ Status-related information is handled less carefully than other confidential information.

MOST COMMON REASONS FACILITIES SCORE PARTIAL

1 **The principle is understood by clinical staff but not consistently by administrative staff.**
A resident's first interaction is often with administrative staff, where the same principle needs to hold.

2 **Care is consistent but documentation habits vary informally based on individual staff assumptions.**
Consistency needs to extend to documentation practice specifically, not only the clinical care itself.

3 **The principle is followed but has never been specifically, formally trained.**
Informal understanding is less reliable than specific, documented training, particularly as staff turn over.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for any differential treatment based on status.

Week 2 Establish specific staff training on this principle, covering all staff, not only clinical roles.

Week 3 Confirm documentation practice is genuinely consistent regardless of status.

Ongoing Reinforce training periodically, particularly for new staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask administrative staff, not only clinicians, about this principle.
This reveals whether the principle genuinely extends beyond clinical staff.

Ask how resident status information, where it becomes known, is protected.
A specific, confident answer reveals genuine practice, not just a stated value.

E-LEARNING academy.gmj.ge/ltc-std9-10-status-neutral-care — 30 min · complete before self-assessment

References

Numbered references below are formal citations, in Vancouver style, each individually verified against the original source before inclusion. The [N] marker on each criterion's Reference line and "The evidence" line corresponds to its number here.

1. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require disclosure to a resident or potential resident, prior to admission, of the facility's specific characteristics and service limitations as part of a genuine admission agreement process.

2. The United Nations Principles for Older Persons (General Assembly resolution 46/91, 1991) establish that older persons residing in any care or treatment facility should enjoy full respect for their dignity, beliefs, needs, and privacy, and the right to make decisions about their care and the quality of their lives, requiring the facility to protect and promote these rights, not merely state them.

3. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit requiring a third-party guarantee of payment as a condition of admission, and require the facility to inform residents before or at admission of services available and their associated charges.

4. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, permit transfer or discharge only for specific defined reasons, require advance written notice, and require a participatory discharge plan developed with the resident and family.

5. The United Nations Principles for Older Persons establish that older persons should be able to live in dignity and security, free of exploitation and abuse, a principle reflected in established long-term care practice as the resident's right to voice grievances without retaliation and prompt facility efforts to resolve them.

6. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to ensure the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision, assistance, and devices to prevent accidents, including falls.

7. The United Nations Principles for Older Persons establish the right of older persons to live in dignity and be free of exploitation and physical or mental abuse, a principle reflected in established long-term care practice as the resident's right to be free from physical or chemical restraints imposed for discipline or convenience, requiring the least restrictive alternative when restraint use is genuinely indicated.

8. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to be adequately equipped with a resident call system that relays the call directly to a staff member or centralized staff work area.

9. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to meet an applicable, recognized fire and life safety standard, including fire-rated corridor doors with positive latching hardware.

10. The United Nations Principles for Older Persons establish that older persons should be able to live in environments that are safe and adaptable to personal preferences, a principle reflected in established long-term care practice as requiring each resident room to be equipped with or located near toilet and bathing facilities supporting genuine dignity and independence.

11. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to provide necessary care and services to ensure a resident's abilities in activities of daily living do not diminish unless the individual's clinical condition demonstrates the diminution was unavoidable.

12. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to provide each resident a nourishing, palatable, well-balanced diet meeting individual nutritional and special dietary needs, with assistance provided as needed.

13. Established long-term care clinical practice recognizes significant unintended weight loss — commonly defined as approximately 5 percent in 30 days or 10 percent in 180 days — as a threshold requiring active identification, response, and increased monitoring frequency once loss is identified.

14. The United Nations Principles for Older Persons establish that older persons should be able to live in environments adaptable to personal preferences, a principle reflected in established long-term care practice as the facility's responsibility to make reasonable efforts to learn and accommodate each resident's cultural and personal food preferences, including documented steps to learn preferences from residents facing barriers to expressing them directly.

15. The United Nations Principles for Older Persons establish that older persons should be able to pursue opportunities for the full development of their potential and remain integrated in society, a principle reflected in established long-term care practice as requiring an ongoing activities program directed by a qualified activities professional to meet the interests and support the physical, mental, and psychosocial well-being of each resident.

16. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require regular licensed pharmacist review of each resident's complete drug regimen, with identified irregularities reported to the attending physician, medical director, and director of nursing, and acted upon.

17. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit psychotropic drug use unless necessary to treat a specific condition that is diagnosed and documented in the resident's clinical record.

18. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require residents using psychotropic drugs to receive gradual dose reduction and behavioral interventions, unless clinically contraindicated, in a genuine effort to discontinue these drugs.

19. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, limit as-needed psychotropic orders to a short, defined duration, with as-needed antipsychotic orders specifically prohibited from renewal unless the attending physician or prescribing practitioner evaluates the resident for continued appropriateness.

20. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to establish and maintain an infection prevention and control program based on the facility's own assessment, with a designated infection preventionist holding specific training.

21. Cohen-Mansfield J. The Unmet Needs Framework for understanding behavioral expressions in dementia, as applied in current long-term care practice, identifies behavior as communication of underlying emotional or physical distress rather than pathology to be suppressed, requiring identification and response to the genuine underlying need.

22. Algase DL, Beattie ERA, Antonakos C, Beel-Bates CA, Yao L. Wandering and the physical environment. Am J Alzheimers Dis Other Demen. 2010 — establishes structured, validated wandering risk assessment, including the Algase Wandering Scale, as the standard for identifying elopement and wandering risk in long-term care, distinct from informal staff judgement.

23. Individualized, proportionate elopement prevention measures, balanced against resident autonomy and freedom of movement, are established practice in long-term care dementia management, distinct from blanket facility-wide restriction applied without individual justification.

24. Tilly J, Reed P. Dementia Care Practice Recommendations for Assisted Living and Nursing Homes. Chicago: Alzheimer's Association — establishes specific, ongoing dementia care training, including communication techniques and person-centered approach, as distinct from general staff orientation, as a core practice recommendation for long-term care.

25. Edvardsson D, Winblad B, Sandman PO. Person-centered care of people with severe Alzheimer's disease: current status and ways forward. Lancet Neurol. 2008;7(4):362-367 — establishes genuine use of individual life history and personhood, not cognitive status alone, as foundational to effective person-centered dementia care.

26. The United Nations Principles for Older Persons establish the right of older persons to make decisions about their own care, a principle reflected in established long-term care practice as the resident's right to formulate advance directives, with the facility required to provide written information about these rights and to address resident complaints about facility non-compliance.

27. Established international clinical definitions of palliative care describe it as patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering, addressing physical, intellectual, emotional, social, and spiritual needs, distinct from and not conditional upon a terminal diagnosis or hospice election.

28. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require a written agreement between the facility and any hospice or palliative care service specifying which entity is responsible for each element of the resident's care.

29. Established international clinical definitions of palliative care describe anticipating, preventing, and treating suffering as central to genuine palliative practice, distinct from reactive response to reported distress alone.

30. Genuine family participation in end-of-life care decision-making, distinct from notification of decisions already made, is established practice in palliative and end-of-life care literature for both improving decision quality and supporting family wellbeing through the experience.

31. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require sufficient nursing staff determined by resident assessments, individual care plans, and the number, acuity, and diagnoses of the facility's actual resident population.

32. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require regular, genuinely accurate public reporting of nurse staffing information, including actual hours worked by each category of licensed and unlicensed nursing staff.

33. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require an effective, comprehensive, data-driven quality assurance and performance improvement program with documented evidence of systematic identification, investigation, and prevention of adverse events.

34. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, establish that the governing body or executive leadership is responsible and accountable for ensuring a quality improvement program is sustained during transitions in leadership and staffing, and is adequately resourced.

35. Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit employing individuals with a documented, substantiated finding of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property, verified through the relevant national or regional screening mechanism.

36. WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force to an ongoing, long-term financial commitment arranged by a family with limited ability to reassess after placement.

37. Continuity of care and family engagement across international distance is identified in cross-border long-term care literature as requiring proactive, periodic communication, distinct from reactive updates provided only when specifically requested.

38. Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and clinical outcomes compared with ad hoc interpretation by untrained bilingual staff or family members.

39. Patient and family-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction, a principle that applies with particular force to time-limited family visits.

40. Medical and long-term care travel facilitation literature identifies documentation delays and errors as a leading cause of placement disruption for international residents, with extended-stay legal status requiring genuinely distinct documentation from short-term medical visas.

41. Cross-border patient and family redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international families face.

42. Medical and long-term care placement governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the receiving facility itself.

43. Established international consular practice recognizes that repatriation of remains across borders requires specific documentation, commonly including a mortuary or transit certificate and an authenticated local death certificate, coordinated between local authorities, the relevant embassy or consulate, and funeral directors in both countries.

44. Genuine accommodation of an international resident's own cultural, religious, and dietary practices, distinct from an assumption of adaptation to the facility's local default, is established practice in cross-cultural long-term care literature for supporting resident dignity and quality of life.

45. Distance and time zone adaptation in family communication, distinct from communication offered only at the facility's own local convenience, is established practice in international long-term care family engagement for maintaining genuine, sustainable connection.

46. WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

47. WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

48. WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

49. WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

50. Nygren B, Hydén LC. Caring for older people with dementia reliving past trauma. Nurs Ethics. 2020;27(2):621-633 — documents that the onset of dementia can trigger the re-emergence of traumatic stress symptoms dormant for decades among genocide and violence survivors, and establishes that knowledge of a resident's life story enables staff to adapt care and avoid retraumatising triggers.

51. WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

52. WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

53. WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

54. Genuine exploration of culturally and religiously appropriate end-of-life alternatives for residents unable to return to their country of origin, distinct from default application of local custom, is established practice in refugee and displaced-population end-of-life care literature.

55. Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

Established Practice — Not Attributed to a Single Source

The statements below reflect genuine, widely recognised professional consensus — drawn from accreditation frameworks, quality improvement literature, and established clinical practice broadly — but are not attributed to one specific paper or document. They are listed here, honestly and separately from the numbered citations above, rather than assigned an invented formal reference.

- Genuine family participation in end-of-life care decision-making, distinct from notification of decisions already made, is established practice in palliative and end-of-life care literature for both improving decision quality and supporting family wellbeing through the experience.
- Individualized, proportionate elopement prevention measures, balanced against resident autonomy and freedom of movement, are established practice in long-term care dementia management, distinct from blanket facility-wide restriction applied without individual justification.

Annex — ISO 9001:2015 Correlation Table

A single-place summary of every criterion's correlation to ISO 9001:2015, for anyone checking this standard's alignment without searching page by page. Criteria not listed here carry no ISO 9001:2015 correlation — this is stated honestly, not implied as a gap in the standard itself; many patient-safety and dignity criteria simply fall outside a quality-management-system standard's scope.

CRITERION	TITLE	ISO 9001:2015

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