

# Long-Term Care Standards

The complete ASF accreditation standard for long-term care facilities. Every criterion is published in full — statement, classification, and the verification questions used by Monitors and supervisors. Free. No account required.

9 standards · 55 criteria · 43 non-negotiable · 12 core · 0 standard · Version 3.0



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**How to read this page:** Each standard groups related criteria. Each criterion has a classification — **Non-Negotiable** (all must be met; any single failure bars accreditation), **Core** ( $\geq 85\%$  for accreditation,  $\geq 70\%$  for certification), or **Standard** ( $\geq 70\%$  for accreditation). The verification questions show what a Monitor checks. To test your facility against these criteria, use the free self-assessment tool.

## STANDARD 1 · MANDATORY

### Admission & Resident Rights

#### 1.1 Admission Agreement Is Genuinely Understood, Not Just Signed

**Non-Negotiable**

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.

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.
2. Is understanding actively verified — for example, through teach-back — before the agreement is signed? — Genuine verification, not assumed from a signature.
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.

#### 1.2 Resident Rights Are Disclosed and Actively Explained

**Non-Negotiable**

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.

1. Does every resident receive a genuine, understandable explanation of their rights, not just a document? — A real explanation, not paperwork filed without discussion.
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.
3. Are rights actively protected in daily practice, not only disclosed once at admission? — Genuine, ongoing protection, not a one-time formality.

### 1.3 Financial Terms Are Transparent Before Admission Is Finalized

**Non-Negotiable**

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.

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.
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.
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.

### 1.4 Transfer and Discharge Protections Are Real, Not Theoretical

**Non-Negotiable**

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.

1. Does every transfer or discharge occur only for a specific, defined, legally permitted reason? — A specific, documented reason, not a general judgement call.
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.
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.

### 1.5 Grievances Are Genuinely Heard and Resolved

**Core**

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.

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.
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.
3. Are residents and families confident that raising a grievance carries no risk of retaliation? — Genuine confidence, not just a stated non-retaliation policy.

## STANDARD 2 • MANDATORY

## Living Environment & Safety

### 2.1 Falls Prevention Is Individualized, Not Generic

**Non-Negotiable**

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.

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.
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.
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.

## 2.2 Physical Restraints Are the Last Resort, Not the Default Response

**Non-Negotiable**

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.

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.
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.
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.

## 2.3 The Resident Call System Reaches Staff Immediately, Every Time

**Non-Negotiable**

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.

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.
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.
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.

## 2.4 Fire Safety Follows a Recognized Life Safety Standard

**Non-Negotiable**

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.

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.
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.
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.

## 2.5 Bathroom and Room Configuration Genuinely Support Dignity and Independence

**Core**

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.

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.

2. Does room configuration provide adequate space and personal storage for the resident's own belongings? — Real, adequate space, not a minimal institutional footprint.
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.

### STANDARD 3 • MANDATORY

## Personal Care & Daily Living

### 3.1 Activities of Daily Living Support Prevents Unnecessary Decline

**Non-Negotiable**

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.

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.
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.
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.

### 3.2 Nutrition and Hydration Are Individualized and Actively Monitored

**Non-Negotiable**

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.

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.
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.
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.

### 3.3 Weight Loss Is Caught Early, Using a Specific Threshold

**Non-Negotiable**

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.

1. Is resident weight monitored on a defined, regular schedule, not informally or irregularly? — A specific, scheduled monitoring interval, not ad hoc weighing.
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.
3. Once significant weight loss is identified, does monitoring frequency genuinely increase? — Real, increased monitoring, not the same schedule continued regardless.

### 3.4 Food and Activities Reflect Genuine Cultural and Personal Preference

**Core**

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.

1. Do food and activities genuinely reflect individual residents' cultural, religious, and personal preferences? — Genuine, individual reflection, not a standardized program applied uniformly.
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.
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.

### 3.5 A Qualified Activities Program Provides Genuine Social Engagement

Core

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.

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.
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.
3. Is genuine resident participation observed, not just a program that exists on paper? — Real, observed participation, not activities offered without residents actually engaging.

## STANDARD 4 • MANDATORY

### Clinical & Medical Care

#### 4.1 Monthly Pharmacist Medication Review Actually Catches Unnecessary Drugs

Non-Negotiable

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.

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.
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.
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.

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

Non-Negotiable

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.

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.
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.

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.

#### 4.3 Gradual Dose Reduction Is Genuinely Attempted for Psychotropic Medications

**Non-Negotiable**

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.

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.
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.
3. Are behavioral interventions combined with dose reduction attempts, not medication reduction alone? — Genuine combined approach, not dose reduction attempted in isolation.

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

**Non-Negotiable**

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.

1. Are all PRN psychotropic orders genuinely limited to 14 days, not extended automatically? — A genuine, enforced 14-day limit, not a routine extension.
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.
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.

#### 4.5 Infection Control Follows a Defined, Facility-Specific Program

**Non-Negotiable**

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.

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.
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.
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.

### STANDARD 5 • MANDATORY

## Cognitive & Behavioral Care

#### 5.1 Behavioral Expressions Are Understood as Communication, Not Managed as Problems

**Non-Negotiable**

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.

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.
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.
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.

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

**Non-Negotiable**

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.

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.
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.
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.

## 5.3 Elopement Prevention Balances Genuine Safety With Resident Autonomy

**Non-Negotiable**

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.

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.
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.
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.

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

**Non-Negotiable**

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.

1. Do staff providing direct dementia care receive specific training beyond general orientation? — Specific, dementia-focused training content, not folded into general orientation alone.
2. Is this training genuinely ongoing, not a single session treated as sufficient indefinitely? — Real, recurring training, not a one-time requirement.
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.

## 5.5 A Resident's Individual Life History Genuinely Shapes Their Care

Core

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.

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.
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.
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.

### STANDARD 6 · MANDATORY

## End-of-Life & Palliative Care

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

Non-Negotiable

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.

1. Is every resident or representative proactively offered a genuine advance directive conversation at admission? — A real, offered conversation, not paperwork provided without discussion.
2. Is this conversation revisited periodically, not held once and never referenced again? — Genuine, periodic revisiting, not a single admission-only conversation.
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.

### 6.2 Palliative Care Is Available Regardless of Terminal Diagnosis

Non-Negotiable

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.

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.
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.
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.

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

Non-Negotiable

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.

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.
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.
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.

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

**Non-Negotiable**

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.

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.
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.
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.

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

**Core**

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.

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.
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.
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.

### STANDARD 7 • MANDATORY

## Governance & Staffing

#### 7.1 Staffing Levels Reflect Actual Resident Acuity, Not Just Headcount

**Non-Negotiable**

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.

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.
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.
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.

## 7.2 Staffing Data Is Publicly Posted Daily and Genuinely Accurate

**Non-Negotiable**

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.

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.
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.
3. Is staffing data retained for at least 18 months, genuinely available on request? — Real, complete retention, not gaps or missing historical data.

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

**Non-Negotiable**

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.

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.
2. Is there at least one annual improvement project genuinely targeting a real high-risk area? — A specific, genuine project, not a symbolic initiative.
3. Is there real evidence the program has driven measurable improvement, not just documented activity? — Actual, measurable improvement, not activity without demonstrated effect.

## 7.4 Governance Sustains the Quality Improvement Program Through Leadership Transitions

**Non-Negotiable**

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.

1. Does the governing body hold genuine, documented accountability for the quality improvement program? — Real, institutional accountability, not dependence on one person's commitment.
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.
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.

## 7.5 Staff Background Screening Prevents Hiring Anyone With a Documented Abuse Finding

**Non-Negotiable**

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.

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.
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.

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.

## STANDARD 8

# Medical Tourism

## 8.1 Pricing Transparency for Ongoing International Placement

**Non-Negotiable**

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.

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.
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.
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.

## 8.2 Periodic Condition Updates Reach Family and Home-Country Physician

**Non-Negotiable**

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.

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.
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.
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.

## 8.3 Language Access for the Resident and Visiting Family

**Non-Negotiable**

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.

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.
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.
3. Can the resident and family genuinely communicate about care decisions, not just exchange pleasantries? — Genuine, substantive communication access, not superficial interaction alone.

## 8.4 Family Visit Travel and Accommodation Coordination

**Core**

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.

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.

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.
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.

## 8.5 Long-Term Residency and Legal Status Documentation Support

**Non-Negotiable**

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.

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.
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.
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.

## 8.6 International Complaint and Redress Process

**Non-Negotiable**

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.

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.
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.
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.

## 8.7 Placement Facilitator and Agent Verification

**Non-Negotiable**

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.

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.
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.
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.

## 8.8 Repatriation and End-of-Life Planning Across Borders Is Discussed in Advance

**Non-Negotiable**

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.

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.

**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.

**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.

## 8.9 Cultural and Dietary Continuity for the International Resident

Core

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.

**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.

**2.** Are these practices genuinely accommodated on an ongoing basis, not just noted at admission? — Real, ongoing accommodation, not documentation without follow-through.

**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.

## 8.10 Time Zone and Distance-Adapted Family Communication

Core

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.

**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.

**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.

**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.

## STANDARD 9

# Health & Migration

## 9.1 People-Centred Care Adapted to Migration and Displacement Experience

Non-Negotiable

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.

**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.

**2.** Is trauma-informed practice genuinely applied, not just referenced as a principle? — Actual practice adaptation, not an assumption of general sensitivity.

**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.

## 9.2 Supporting Resident Agency Through Genuine Understanding of Care and the Facility

**Non-Negotiable**

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.

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?"
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.
3. Is information communicated in plain language, avoiding jargon, particularly when working through an interpreter? — Complex terminology strains interpretation and comprehension together.

## 9.3 Language and Communication Aids — Interpreters and Cultural Mediators

**Non-Negotiable**

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.

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.
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.
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.

## 9.4 Collaborative Practice Across Health and Social Services

**Core**

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.

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.
2. Does handover to another provider specifically include migration- and displacement-related context? — Specific inclusion of this context, not a generic handover.
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.

## 9.5 Trauma Resurfacing With Cognitive Decline Is Recognised and Addressed

**Non-Negotiable**

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.

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.
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.

3. Are care practices — bathing, personal care, restricted movement — reviewed for retraumatizing potential? — Specific, individual review, not a generic assumption.

## 9.6 Evidence-Informed Care for Refugee and Migrant Elderly Residents

Core

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.

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.
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.
3. Is practice adapted where population-specific evidence indicates a different approach is warranted? — Actual practice adaptation, not awareness without application.

## 9.7 Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

Non-Negotiable

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.

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.
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.
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.

## 9.8 Legal Status Diversity Recognition

Core

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.

1. Can staff name the specific legal status categories this facility actually serves? — Specific, named categories, not a general sense that "migrants" are served.
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.
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.

## 9.9 End-of-Life Planning Honours the Resident's Culture When Return Home Isn't Possible

Non-Negotiable

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.

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.

**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.

**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.

## 9.10 Care Is Documented and Provided Regardless of Immigration or Legal Status

**Non-Negotiable**

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.

**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.

**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.

**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.