Louis Feinstein Alzheimer's Center
Cranston, RI

Theme
How do you take your coffee?

What this case study shows:
• How a collection of meaningfully different spaces successfully accommodate a variety of concurrent activities.
• The value of visual connections: from room to room, from inside to outside.

Place Profile

Director
Cynthia Conant-Arp

Facility type
Purpose built facility

Building size
Approximately 6,500 square feet

Construction completed
1995

Architect/designer
Robinson Design, Smithfield, RI

Program

Mission and goals

The mission of the Louis Feinstein Alzheimer's Center is to fulfill the needs of those with Alzheimer's disease and to do so in a way that optimizes each person's independence and dignity. This attitude is evidenced by the Center's "Participant Bill of Rights," which pledges that day care participants:
• Be treated with respect, dignity, and compassion
• Experience a safe, secure, clean and home-like environment
• Have the right to privacy
This focus on the dignity of the participant influences the way in which the Center's mission is realized. Care staff begin by focusing on each individual's existing abilities, emphasizing strengths to enhance each person's self-confidence. The philosophy is not to simply meet the need, but to challenge and stimulate each participant according to his or her abilities.

General description

The program at the Feinstein Center operates Monday through Saturday. All participants suffer from some form of cognitive impairment. There are five primary program areas--the family/living room, dining area with breakfast bar, breakfast nook, den and occupational therapy (OT) kitchen. Most activities take place either in the dining area or the family/living room. Participants begin their days with coffee at the breakfast bar, then proceed to the family/living room for cognitive and physical exercises around 10:30 a.m. Days at the Feinstein Center are planned around three activity blocks (one in the a.m. and two in the afternoon) during which four to six different activities run concurrently. Director Cynthia Conant-Arp discusses the program strategy:

ADC 1

(In addition to the) three activity blocks, there are activities that happen throughout the day that aren't part of that formal block. The blocks of time are all preassigned both in terms of staff and participants. The more informal activities happen throughout the day, and at the very end of the day often the activity may be a couple of the CNAs leading a sing-a-long or a group doing some reminiscing, or a game, or a trivia group, or looking at photographs of old movie stars.

Services offered at the Louis Feinstein Alzheimer's Center include

- breakfast, and a hot noontime meal (feeding assistance as needed);
- arts and crafts
- games
- dancing and sing-along
- physical exercise
- reminiscence
- pet therapy
- showers
- toileting assistance
- medical services (i.e., medicine distribution, podiatry, skilled nursing)
- social services (i.e., participant assessment, family support, financial support)

Full fee charges are $56 per day. State assignment and sliding fee scale charges range from $35-48.

Staffing

The Feinstein Center has 21 staff members (FTE total of 16.5). With an average daily census of 45, the typical staff to participant ratio is approximately 1:3.5. This ratio varies through the course of the day and affects the choreography of the program. When census level is lowest (early morning and late afternoon), the number of staff is reduced accordingly and with that, fewer spaces and activities are engaged. Staff are predominately female with nursing training (four are registered nurses and nine are certified nursing assistants). Eight staff members are administrative; 15 are primary care staff. Nine of the 21 staff members have been with the center since its opening in 1995.
We don't use agency people at all. They really can't be very helpful. The staff comes to us because they are interested in the concept of adult day care. Certainly the nurses find a community-based program helpful in meeting with the needs of their own personal lives, especially if they have young children because it's more conducive to their lifestyle. The nurses usually also enjoy being more person-oriented than task-oriented...I can't tell you how often that's cited as a reason for looking for a new job. They have felt that with the pressures of health care today they're not able to provide the kind of quality care that they want to and which this community-based setting allows them. So our nurses have come with broad backgrounds. Many have worked in either home care agencies, nursing homes or in hospitals, in some cases all of them. We recently hired a nurse who'd been working for a long time in the orthopedic ward of a very large hospital and came to us as a volunteer because she wanted to know that there was another way to do things. We hired her after the volunteer experience.

Our certified nursing assistants come from a wide variety of backgrounds too. We just hired three out of a hospital inpatient program that was being downsized. In almost all cases the people we hire have had geriatric experience in the past. In a very few cases we'll hire brand new people who've just received certification. In some ways that's good too, because they bring the high energy and we're able to train them according to our philosophy of care.

To return to the per diem issue, we believe it's terribly important to have consistent staffing. There are times when people are sick and we need an extra set of hands. But we make certain that every per diem gets some advance training so that they know us, and at least their face is familiar to other staff and participants before they actually are engaged to work for a day.

Participant profile

The Feinstein Alzheimer's Center has 85 enrolled participants, a self-imposed maximum daily census of 50 participants and an average daily census of 45. The Center serves 23 Rhode Island communities, in effect, most of the state. Conant-Arp talks about the program's appeal with additional comments offered by social services team member Ellen Grizzetti:

We're centrally located, which makes it very helpful in recruiting participants, where some of the other centers are quite remote. But transportation is an issue. A lot of centers provide their own transportation in addition to relying on the Paratransit (state-operated) program. We haven't needed to yet, and I hope we never do.

Because we have the space and the capacity to run multiple activities at once, we can really focus on the individual. We have the ability to make an early Alzheimer's victim a star—more like a volunteer here. That makes for a nice transition to the program. We may buddy them up with someone who needs support, or with a peer if they're demonstrating some resistant behavior, not wanting to come to the center. We bill ourselves as the facility for Alzheimer's and we will do all we can to support
your loved one for the long haul. When we talk to families we try to approach it by saying that we will help you according to the level of your need, and we’re there for as long as you need us. In most cases we’re there until very near the end, sometimes to the end.

Institute  Was that a philosophical position you began with, or has it simply evolved as your participants needed more?

ADC 1  I think we began with it and it’s strengthened as we have evolved as an organization. For example, when some of our people became medically intensive there was some discussion: Is it appropriate to direct that much staff time to help one individual? I think we’ve come pretty much to the consensus that, yes, it is appropriate until such time as the family is ready for the next transition. It’s our responsibility to provide the support and the education to effect that transition. Sometimes we have to just push things a little bit, though not often. Sometimes we need to get family in and sit down and have a heart-to-heart. It’s when we feel like our staff are at risk of injury and that kind of a thing. That’s really what pushes us over the edge usually.

ADC 2  I can tell you that we’ve been pressured on several occasions to introduce geri-chairs for more advanced participants.

Institute  Pushed by?

ADC 1  By caregivers, some physicians as well...at this point our staff is really uncomfortable with the idea, because we feel it makes us more of an institution. It’s not a clear-cut issue, because we also want to help families, and not having them limits the amount of help we can provide to the very advanced cases. On the other hand, we have to think about the comfort of the larger group. I don’t know that we’ve come to any firm resolution, but for now we’ve reached consensus that we prefer hominess to the institutional flavor that we believe geri-chairs would introduce.

Participants are as young as 56 years, with an average age of 82. The gender ratio is one male to two female. Ninety-two percent of participants are white; approximately four percent are African American and five percent are Hispanic. All of the participants have a diagnosis of Alzheimer’s or a related disorder. Fifty percent of participants require some form of mobility assistance and 16 percent use wheelchairs. Fifty-nine percent are incontinent, and 42 percent are dependent in three or more activities of daily living. The intake process uses a "get-acquainted approach" strategically:

ADC 2  Things get started when we receive a signed form from the physician...then we invite the family in, together with social services and the RN...we go over all of our policies and procedures to kind of get an initial picture of the participant. While we’re having that meeting with the family, the person is introduced to center activity, kind of a little orientation period. They feel more reassured that "I don’t stay here, I go home, there aren’t any beds here," that kind of thing. We do some one-on-one and draw on whatever ability he or she has to remember being here by making sure
that the same staff person will be here on their next visit to the center, which will be for the full day. We really don’t do a half-day thing. Probably during the first week of attendance we’ll do an assessment of the participant.

**Institute**

Do you ever turn people away?

**ADC 1**

Everybody gets a chance, even if we are very skeptical about the likelihood of their success in the program. We believe that everyone deserves a try.

**ADC 2**

But we do have a two-week assessment period agreement that we ask families to sign on admission; the time period is actually shorter than that if necessary. It kind of protects us if somebody really is extremely difficult.

**ADC 1**

...or had inappropriate behavior. We have had a couple occasions where there was overt sexual behaviors or overt aggression. Even in the cases when we discharge, we suggest alternatives and ways in which the problems might be remediated so that there’s some chance to come back and try again.

**Institute**

What’s your success rate when people walk in to stay?

**ADC 1**

It’s extremely high. If we get them through the door to actually see the facility during the day care day, it’s close to 100% conversion rate.

**ADC 2**

It’s very rare that we have people claiming: "My loved one isn’t happy here." You know, if the caregiver is on board, you’re 90% there. With a reluctant caregiver, forget it. If the primary caregiver won’t encourage that person in the morning and get them on the bus, it will never work.

**ADC 1**

Sometimes the individuals who come to us have been homebound for so long, and the caregiver has completely wrapped his or her identity around that person... it’s very hard to assess that separation. It’s highly individualized. In those cases, the relationship will be redefined. What we try to do is help the caregivers enjoy a new quality of the relationship with less task orientation.

**Institute**

It’s a process of reconstruction.

**ADC 1**

Right. Many times people come to us "incontinent" and "unable to feed themselves," when all that’s needed are some reminders, some cueing and an environment that’s conducive to maximizing ability.

**ADC 2**

"She used to be a great cook, but she can’t do that anymore." "She used to do needlework all the time." We hear those kinds of comments because you know it’s your mother and you want her to be all she was. We just know them for today, so we rely on what they’re still able to do. People walk away feeling good about themselves again.
The Feinstein Center is situated on 19 acres of city-owned parkland. By car, one approaches via an extended, winding route: a makeshift directional sign placed at a crossroads is intended to eliminate wrong turns. Parking spaces are placed toward the outside of the loop, away from pedestrian travel, and spaces are grouped in clusters of six or less.

Participants are dropped off under a canopy that extends from the airlock vestibule. The airlock has windows on both sides, which provide light and a sense of spaciousness. From the airlock, one enters the foyer, outfitted with French Provincial-style furnishings. To the right is a small sitting area with two chairs and an end table. To the left is a library table with participant nametags, brochures and guest book. At the far end of the foyer is a stylish mahogany reception desk. Behind the desk is a six-paned interior window that provides a view into the main program space. Walls are white-painted drywall with wood detailing. The floor is carpeted.

To the left of the foyer is a personal care area, which provides storage for participants' personal items (i.e. a change of clothes); this area is accessible also from the shower room.

To the right of the foyer are staff areas, including a social work office (originally intended as maintenance space), nurse's offices and staff work/breakroom. These spaces all have plain wall finishes and acoustical tile ceilings.

A solid paneled door leads from the foyer into the primary program space. Once inside, one encounters the "U" shaped breakfast bar, constructed of deep green laminate. Windsor-style wood chairs are spaced around its perimeter.
The breakfast bar projects into the dining area, a large space that serves for dining as well as large group events. Two large skylights admit ample natural light. An expansive window wall faces southeast and looks out onto a tidy patio garden. Interior walls have windows (also termed "vision panels") that provide views into adjacent rooms. Recessed incandescent light fixtures and sconces supplement natural light. The ceiling is acoustical tile. The walls feature vinyl wallpaper and ceiling border trim and a wood chair rail. Flooring is wood-look vinyl.

The wall between the dining area and the family/living room features two sets of wood and glass French doors. This architectural device allows visual connection and provides a means of privacy and sound control between the two rooms when the doors are closed and the blinds are drawn. The family/living room is an irregularly shaped room consisting of a large main space and alcove. The furniture in the living/family room is institutional (vinyl seats and backs with wood arms), and typically arranged with two long tables placed end to end to the north and a circle of chairs (such as for discussion) set up facing the alcove but extending well into the main space. The arrangement results in part due to an accordion door at the midpoint of the room. While the alcove was originally intended as the location for the activities director's desk, its placement in the open prompted rummaging behavior and has since been removed. The room has carpeting, white walls and an acoustical tile ceiling. An exterior door provides access to a patio area oriented for morning sun.

A wandering path surrounds the service pantry. Located along this path are the occupational therapy (OT) kitchen and its adjacent breakfast nook. Both rooms are residential in feel, with areas for cooking and baking as well as mealtime assistance. The OT kitchen has upper and lower cabinets with undercabinet lighting and a counter for OT therapy. There is a
refrigerator, stove and kitchen sink with a window above. The breakfast nook has a service window detailed like a residential breakfast bar. Windows on two sides help create a feel for the breakfast nook that is light and airy. The room is painted white and has vinyl sheet flooring.

Behind the breakfast bar is the service pantry in which kitchen activity is conducted and meals are plated by staff. In use, the pantry has proven to be a rather cramped space, evidenced most at lunchtime. However, its spatial relationship to the breakfast bar and the aromas that are produced as a result of kitchen activity are strong positives of the scheme.

While there are five toilet rooms with a total of five fixtures scattered throughout the facility, two rooms are somewhat remote from the most used program spaces. Thus in effect, there are three toilets serving 45 participants per day. Further complicating things is the fact that two toilets are located in shower rooms; when showers are occupied, these toilets are unavailable for privacy’s sake.

The Feinstein Center has no tubs, rather, participants are bathed in showers. The assisted shower room has ceramic tile on the walls and floor. A second shower room stands idle as it requires independent use.

Ancillary spaces consist of a room for medical visitations, respite and therapies as well as a beauty salon. The secure outdoor space consists of a treed area with planting beds and a wandering loop overlooking Brayton Park. While the area is secured only by a wooden picket fence 4½' high, elopement has not been a problem.
Coming and going

Dropped off by van or family members, participants begin to arrive at the Feinstein Center as early as 7:00 a.m., though the majority arrives between 8:30 and 9:30. Passing through the main door, one is welcomed by the sight of the breakfast bar. Staff are quick to meet newcomers and involve other participants in greeting arrivals.

Institute

I know Rhode Island is small, but coming from all over the state means some substantial travel times. What's the maximum travel time for participants?

ADC 1

We participate in the statewide Paratransit System as well as the Americans with Disabilities Act Transportation System. There are some families who choose to transport privately. In one case we even had a lady who arrived and departed in a limousine. They were paying $100 a day for transportation and only $50 to attend day care! The Ride Program aims for no more than one hour on a bus, and I think for the most part they're successful. For other facilities I've known transport time can be as long as two hours each way. That definitely would be problematic for the population we serve.... Under an hour generally is manageable, and we do plan for some ADL assistance right before bus time.

Departures have a different character. While arrival is associated with a sense of relief and destination, departure is anxious. Participants are more likely to be agitated by late afternoon and tend to gather by the exit door near the breakfast bar. For some, the anticipation of leaving may last for several hours. They sit at the breakfast bar or turn chairs in the dining area to face the door. This situation, which raises the stress levels of all present, is caused by the inevitable fatigue and associated anxiety that results from activity of the day.

Institute

With the census a third larger than you initially anticipated, how do things work in the morning coming and going, people arriving and taking off their coats, boots...?

ADC 1

We usually assign one person to that front door.

Institute

Does it usually get a bit jammed up or are you able to space arrivals?

ADC 1

It can, but I think we have enough staff that it's never a source of frustration. In the afternoon I think it's a little bit more problematic, because most of the busses come between quarter of four and quarter past four.

ADC 2

And the anxiety level is just a tad higher.

Institute

How do you manage it?
A couple of ways: we try to keep folks in activity for as long as possible, because downtime is when anxiety really starts to gel. We don't bring coats out onto the floor. As the bus arrives, they come in with a list of names of who they're collecting, and one staff person goes out onto the floor to gather those folks.

Institute

Do busses typically arrive in the same order?

ADC 1

No, but the drivers know to line up and they know that only one bus will be loaded at a time. We're very adamant about that. We're just as careful as we can be. It works pretty much without a glitch, but our folks get anxious that time of day. Seven hours is a long time.

Primary Program Space

Activities at Feinstein take place in five different areas but are concentrated in three: the dining area, the breakfast bar and the family/living room. The presence of multiple spaces not only permits concurrent activities but maximizes uses of the setting.

Early in the morning, participants arrive and have breakfast at the breakfast bar, the first "activity" destination. After breakfast participants proceed naturally from the breakfast bar to the family/living area, where they engage in a cognitive activity. Large group events take place in the dining area, the largest space in the facility.

ADC 1

Most days, following breakfast we have our first activity block of the day, usually around 10:30 and we go into about five different activities. Some are for our earlier stage folks, others are for people interested in crafting, outdoor folks that want to walk, that sort of thing. There are usually five or six different things going on. On Mondays, though, we have a wonderful entertainer who comes in. He plays the guitar and sings--he's great with our folks. They get up, they sing, they dance, they do it all. In that case, it's really impossible to have more than one activity because, although we like smaller groups, the music just draws everybody in. He has the undivided attention of our folks.

ADC 2

I was going to say that there are a few people who don't handle that stimulus well. You'll see two or three stragglers back in the living room who won't join in, but for the most part everyone is engaged.
Right, the volume can overwhelm them. But while it's happening--they're engaged and you don't need as many people on the floor--our nurses take the opportunity to do personal care. So, Monday mornings are a great time to get a lot of showers done; they generally do four or five during that activity time. Bathromming happens then, too. When Lou (the musician) wraps it up at around quarter to twelve, we do our bathromming for lunch, and then everyone is transitioned to the dining space.

Afternoons, four groups are run concurrently. The French doors and interior windows allow participants to visually sample and choose among activities; vicarious participation is permitted as well. The alcoves and niches throughout the facility afford more intimate discussions and/or limited involvement in the main activity of the space. Similarly, the outdoor area can be used as a more private sanctuary, with participants taking time out for a breath of fresh air.

**Kitchen and kitchen work**

No kitchen work as therapeutic activity was observed. However, the occupational therapy kitchen appears reasonably laid out, providing enough workspace and access for participants to participate in meaningful baking activities.

By contrast, the service pantry (behind the breakfast bar) has proved too small a space for efficiently serving lunch to 45 participants. With two staff plating meals and one checking trays to ensure dietary restrictions are met, service bottlenecked at one side of the breakfast bar with three or four staff waiting to serve trays.

**Dining**

A large group activity is held in the dining area just before lunch, so the dining experience begins with staff and participants repositioning tables and chairs for lunch. Often, it is participants who are first to begin the rearranging, in effect, creating a meaningful activity that exercises functional abilities.

At the Feinstein Center, participants have four options for dining: in the dining area; at the breakfast bar; at the counter of the OT kitchen; and in the breakfast nook. In the dining area there are two table sizes: square tables for four
people and a few two-person round tables. The breakfast bar offers seating for eight at a counter where staff can assist participants. The OT kitchen counter provides a location for those who enjoy kitchen ambience or desire separation from the stimulation of the larger room. Finally, the breakfast nook offers a sunny yet private environment for participants who need assistance with eating.

Given dietary restrictions and the fact that trays must be assembled individually, efficient service can be a challenge. It was not uncommon to see one person at a four-person table served lunch 10 minutes before their tablemates received meals.

\*ADC 1\*  
Usually people have a "regular" table that they sit with and it's sort of their choice, kind of the way friendships develop in any age group. That works out well. The nurses always oversee the lunch. They change the texture of the food for the people who need it, keep an eye on table settings and so on. Some of our folks are served in the back kitchen area and some in the main dining room.

\*Institute\*  
How do you differentiate?

\*ADC 1\*  
It's usually people who require more assistance with feeding, or if we get the sense that the noise level is too much for them. Everybody pretty much starts in the large dining room, we go from there. If we feel it's not working, perhaps they're just not eating well and we don't know the reason, we've tried less utensils, tried assistance and nothing seems to be working, then we'll try that quiet space.

\*ADC 2\*  
We also have some people seated at the breakfast bar, primarily folks who have problems with swallowing. The nurses use the breakfast bar as a mini nursing station at lunchtime, and the great thing is, it doesn't look institutional. So they're able to supervise right there.

\*Institute\*  
Yes, the breakfast bar seems to be a wonderfully elegant way of solving the need for the typical U-shaped table, where everyone knows what it's there for and why it's there. This does all the same things, but it's absent the stigma.

\*ADC 1\*  
We love that. It's a great place for activities in the afternoon too. They've squeezed their own lemonade there, and had a lot of cooking groups. Even a small bingo might get called there or a sing-a-long or whatever. It's great.
Toileting

The Feinstein Center has five toilet rooms with a total of five fixtures, though two rooms are somewhat remote from the actively used program spaces. Thus in effect, there are three toilets serving 45 participants per day. This would not be enough if it were not for the Center's toileting program of regularly scheduled "potty visits." The execution of this schedule is illustrated by staff engaging participants in an activity (such as dancing during a music presentation) and simply moving the activity toward the toilet. Participant dignity is retained, stigmatization reduced, and potential interruptions to group-programmed activities minimized.

**Institute**  
*It seems that lots of day care providers face a problem of bathrooms five or seven years later. The bathrooms they built weren't spacious enough to accommodate a two-person transfer and things of that sort. How has this been for you?*

**ADC 1**  
*Yes, we had that frustration (in our former facility), so we made sure the architect understood, and now we really don't have that problem here.*

**ADC 2**  
*We've even done the occasional three-person assist, but there we had to look at the benefit to participant and benefit to program of doing three-person assists...*

**Institute**  
*That's pushing the risk?*

**ADC 2**  
*Yes, that's pushing the risk to staff. Now we're faced with the question of, "Is this time for a Hoyer lift?" It's really not appropriate in this setting. It's one of the discharges we've had to effect.*

Showering

The Feinstein Center does not offer baths but does give three to four showers daily. Although there are two shower fixtures available, the independent shower stall goes unused. Of note is the fact that the architect made allowances in one of the shower rooms for the future installation of a tub. The decision process is recounted here by the architect, John Robinson:

**Architect**  
*What had happened was we couldn't decide if we should have a side entry tub or not. So we agreed to design a space for a shower and leave enough room so that if later on we want to bring one in and try it out the space would be available. So that's why we have this long shower. That electrical plate is there for the eventual/possible...*

**Institute**  
*You haven't felt the need for a tub to date?*

**ADC 1**  
*No, and actually after talking with colleagues and nursing homes, they expressed their concern about side-entry tubs and Alzheimer patients. The patient has to get into the tub before it's filled and there's a lot of noise associated with filling the tub. At least from my colleague's perspective, it was a very frightening process.*
Wandering

Not much wandering was witnessed at the Louis Feinstein Alzheimer's Center. Perhaps the number of environmental choices available fosters enough diversion to reduce the pacing associated with agitation. Also, in the course of activity programming there is a great deal of movement between rooms, an integration of physical exercise that allows participants to release energy through the normal progression of the day.

Outdoor space

With access to nature all around, the Feinstein Center sits on a 19-acre site overlooking a city park. While not fully developed, the outdoor space does provide a wandering loop and some opportunities for engagement (e.g. a raised planting bed). As important as the ease of accessing the out-of-doors for a moment of solitude or for the opportunity to maximize functional abilities is the visual access provided to the outdoors throughout the facility.

ADC 1

We just started our pretty season here, but if you could see this in the fall, it is magnificent. We've had ponies in the backyard, we've had a carnival in the backyard and it's been wonderful. I know it's very small, but it's spacious enough for the census that we're serving.

I think that one of the major problems encountered by adult day programs for dementia is that in creating the margin of safety and finding an affordable solution, they often neglect the outdoor spaces, and I really feel that's a big part of our success here. Even for those who aren't actively able to enjoy the outdoors, the outdoors is brought to them through the use of glass. Perhaps that's an oversimplification, but I really do think it's critical to our success.

(Case in point regarding the outdoor space) is one of our participants. This woman firmly believes she's the president of the garden club here. Now we believe in reaping what we sow, and integrating those situations into our programs. It's really been very beneficial. It's our responsibility to reach the person trapped inside. Sometimes the vehicle may be gardening, sometimes music or art, it may be reminiscence. No matter, in some way we have to reach those individuals, and it's nice to have the resources to be able to offer the alternatives.


**Advice For Other Providers**

**ADC 1**
I would love to be part of a senior campus. Not necessarily a senior campus, but a campus that allowed people the sense of community that's so important especially to our elders. A place where there's an opportunity for independent living, an opportunity for assisted living, an opportunity to receive some services within a private home-like environment, an opportunity to benefit from the services of an adult day center, where there's a community center in which folks can participate. I'd like to think that someday there'll be not necessarily one-stop shopping, but at least there'll be a range of services within the same community setting and I would love to see that happen.

**Institute**
Is the goal that such a campus not be located on its own 40 acres isolated from the rest of the world, but truly knit into the community?

**ADC 1**
Right, but at the same time it needs to have enough of a physical environment, an exterior physical environment. It's a park-like setting like this that's pastoral and where people actively interact with the physical environment that's so important in our facility here. It's a key to who we are as well, because it creates the sense of freedom here, not entrapment.

**Architect**
One of the greatest things you see here is what a positive impact this facility has had on some people's lives, some families. At the facility's one-year anniversary, there were a few different couples giving testament, but one couple recounted the story of how difficult their lives were. The emphasis was on turmoil: their lives were in such turmoil and depression, and within a year of arriving here, everything had changed. It was tremendous. It's not just the architecture obviously...

**ADC 1**
No, but the architecture makes that possible. I really think that the people and the architecture work together. If I define quality in adult day center, I'd have to define environment, communication skills with staff, organizational philosophy and the capacity to do behavioral interventions with the caregiver, the care provider, and our staff. It's about changing behavior in order to effect a change.

**Architect**
I've seen in other facilities and nursing homes for the elderly that were designed wonderfully, but they just didn't have the commitment. Things get tough, and the next thing you know administration reacts by locking doors....