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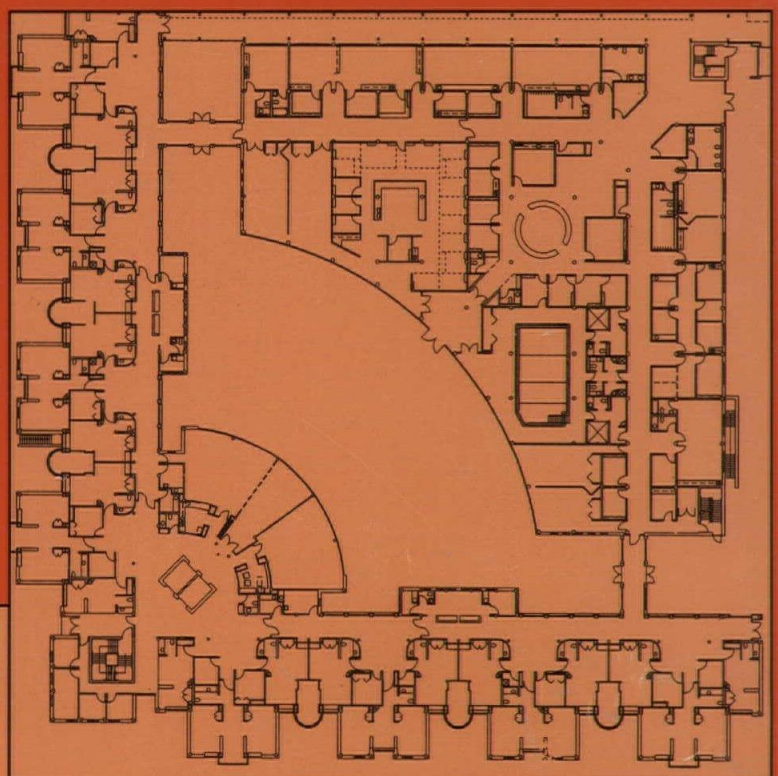
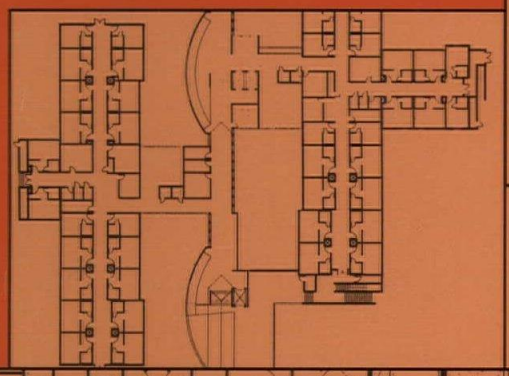
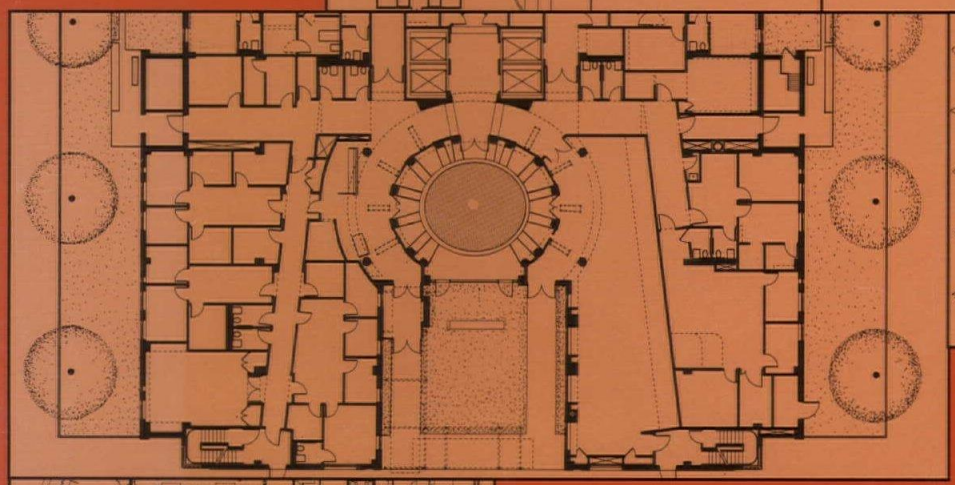
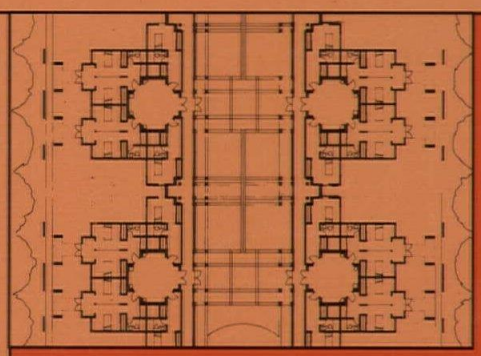
PROGRESSIVE ARCHITECTURE

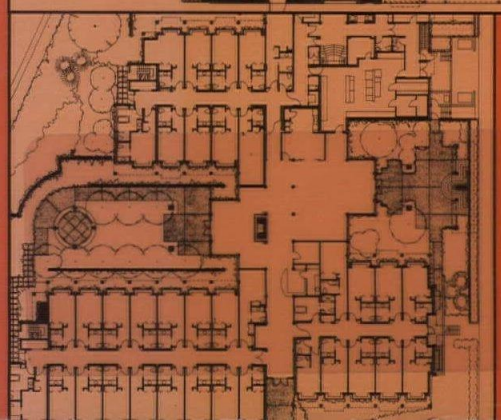




Long-Term Care Facilities







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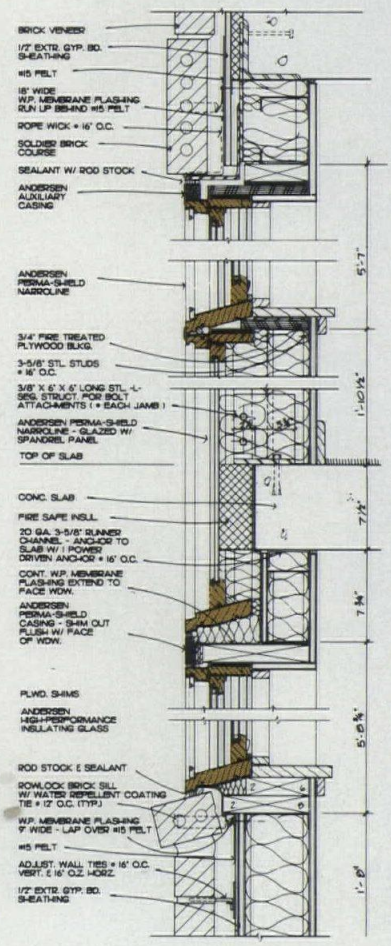

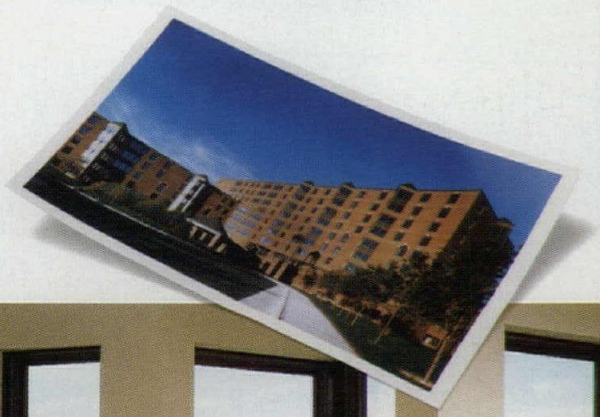

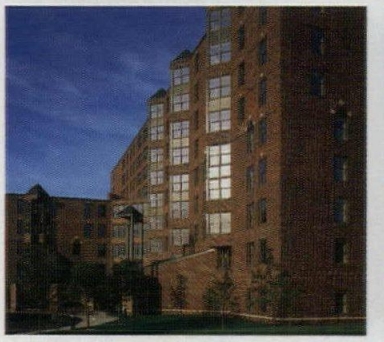

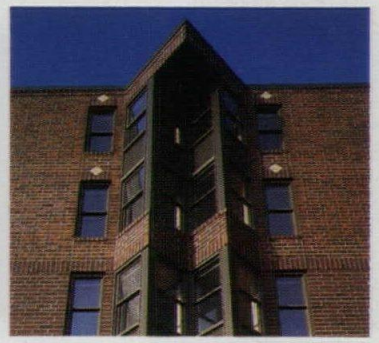

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P/A Plans

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How to Bring Your Brightest Ideas Out of the Shadows.

through a haze of cigarette smoke i saw the band launch into an old Cole Porter favorite. but they improvised, stretching the barriers of the tune, finding new life in an old structure. some listeners just couldn't dig it, but for those who did it was real and beautiful and a moment to be savored.

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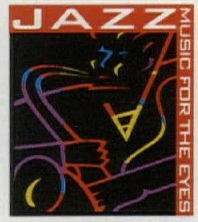

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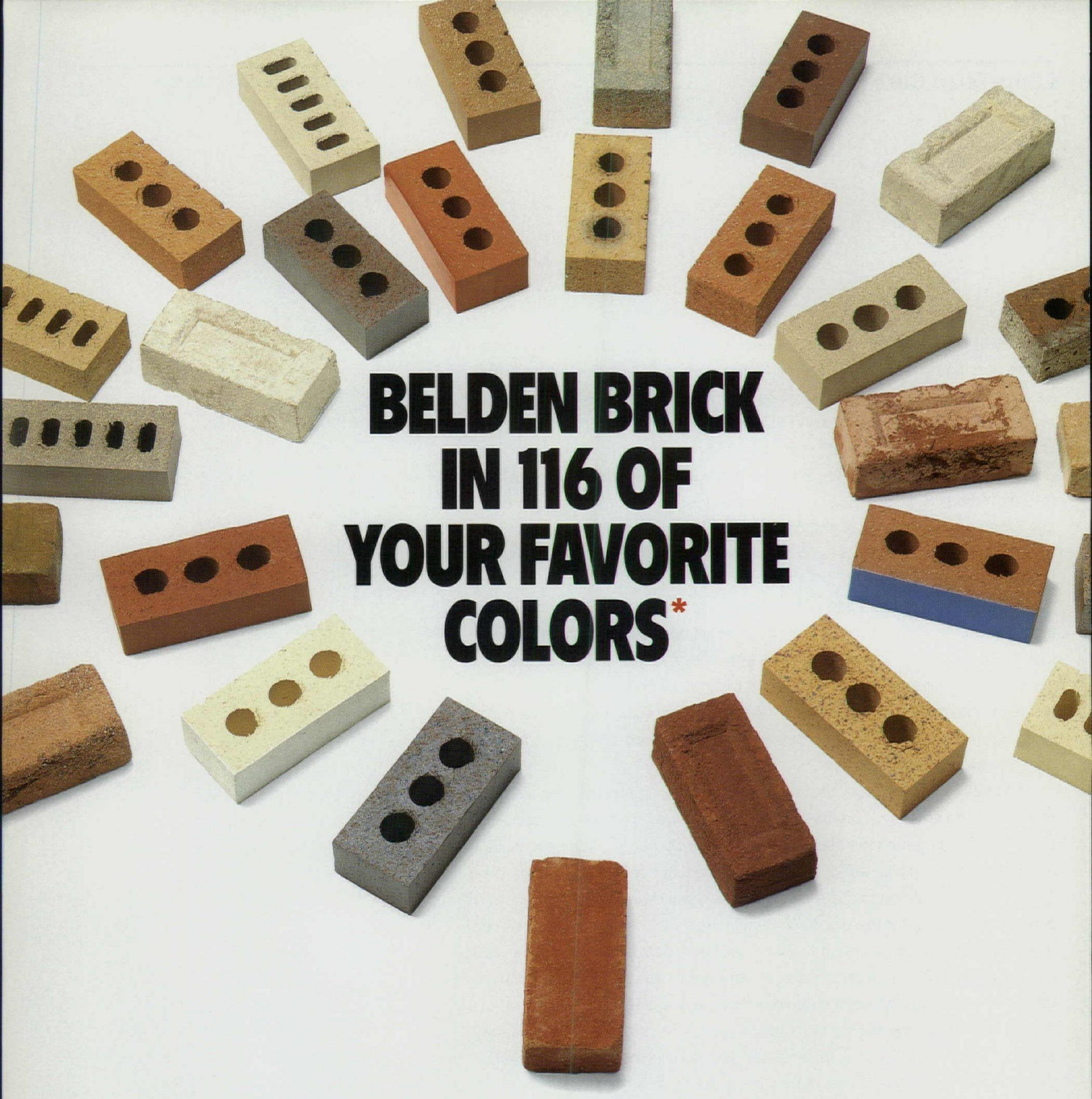
Long-Term Care Facilities

Long-term care facilities, which include everything from retirement communities to nursing homes, have been and will continue to be an active area for design services. There are many reasons for this. Our population is aging, as architect Bradford Perkins notes in his essay on page 9, with the large baby-boom generation only 20 to 30 years away from retirement. Also, public policy on this issue seems to be changing: the various groups pushing for healthcare reform in the U.S. all seem to recognize the need for a coherent system to pay for long-term skilled nursing care. Finally, the average life expectancy of people continues to increase with advances in medical diagnosis and patient treatment.

Unfortunately, the design of long-term care facilities has had some catching up to do. As Victor Regnier concludes in his new book on the subject (page 13), overly restrictive regulations and a relative lack of public support for such facilities have caused U.S. projects to lag behind those in Europe in terms of both design and operation. "We have created a long-term care system," says Regnier, "that is fear-based. It assumes incompetency and violation of standards are the norm."

We have assembled, in this issue of P/A Plans, a group of long-term care facilities in the U.S. and Canada that we think go way beyond the norm in terms of providing humane settings for frail, elderly people. We have included 31 projects by 27 firms, out of a total of 52 projects sent to us by 43 North American firms. Although the projects in this issue represent a continuum of care, from housing for the elderly that includes a few medical treatment components to critical-care nursing facilities, we have decided to divide the work into three parts. The first encompasses retirement and total life care communities, whose residents need a minimum of medical service. The second section includes a variety of long-term special-needs housing, such as an eating disorder facility, a children's crisis center, and housing for people with AIDS. Skilled nursing facilities, some of which are devoted to or have sections set aside for people with dementia, comprise the third part.

As we were putting this issue together, the editor in charge of it, Jim Murphy, died unexpectedly of a heart attack (see the July issue, p. 9). As with everything else that he did, Jim had this issue very well organized, allowing other editors to pick up his work without a hitch. We dedicate this issue on long-term care facilities to Jim, whom many people cared about and whose life was, regrettably, much too short. **Thomas Fisher**



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The Next P/A Plans: Public Libraries

In early 1994, we plan to publish plans of public libraries. These can be of any size or location, and can involve new construction or additions to or renovations of existing libraries. The deadline for submission is December 1st, 1993. Address submissions to: P/A Plans Editor.

For those who want to submit projects, we need clear, unlabeled black and white floor plans in the form of photostats (PMTs, K-5s), with graphic scales and north arrows. Room functions should be supplied on accompanying photocopies of the plans. We also need two or three clear photos (prints, slides, or 4x5 transparencies are acceptable) of the completed building or a model or rendering of the project.

To ease our review of projects and the production of the issue, we ask that you provide the following information for each project that you submit.

Project:

Architect:
(include credits for people in firm
plus the names of associated architects)

Client:

Program:

Building area:
(net and gross square feet)

Cost:
(per gross square foot, and year of construction)

Major materials:
(list should be brief)

Consultants:
(list firm names and specialties)

CAD-developed?
(yes or no)

Architect's statement:
(about 150 words, describing design intent)

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Principles of Long-Term Care

Architect Bradford Perkins of Perkins Eastman & Partners in New York discusses eight emerging trends in the design of long-term care facilities.

Demographics predict a doubling in the number of old people in the U.S. in the next twenty years. This rapidly growing segment of our population, however, will not be homogenous. Some will be very frail and confused, some will be merely frail, others will function independently — and very few will consider the current residential and long-term care options available to be an appropriate response to their real needs.

For this group, more than for any other major segment of our population, the built environment can be very limiting or very supportive, enhancing people's health, independence, socialization, privacy, and dignity. But what is being built to meet this important need? The majority of the new construction has been sterile nursing homes and formulaic congregate care facilities. There are a growing number of exceptions, but most of what has been built are direct, knee-jerk responses to misguided architectural models, codes, and reimbursement formulae. Most of these facilities consign our frail elderly to live out their lives in typical hospital semiprivate rooms with only a curtain separating roommates.

This minimum response to the needs of the frail elderly can also be seen throughout the bathing, dining, and activity areas of facilities designed to current codes in most states. Codes and reimbursement formulae often encourage facilities that have less than 500 gross square feet per resident (less than a short-stay Holiday Inn program) and 180 gross square feet for a "semiprivate room" (about 20 square feet more than is allocated in a typical maximum security prison — and this, presumably, for a lifetime of good behavior). The added cost of a better room rarely translates into more than $1.00 per day per resident. The model in the code is a custodial, hospital-like environment; the need is for a residential setting, with health and other support services.

Few facilities are designed to respond to the special needs of many of their residents. There is no "average" elderly person, but the codes assume there is. The typical nursing home resident in the future will be older, frailer, and more likely to suffer from Alzheimer's disease and other forms of dementia, but each will have her own unique needs. In spite of these trends, many older nursing homes are not barrier free for an increasingly chair-bound population, and few have units that incorporate the latest research on the care of people with Alzheimer's and dementia.

"Codes and reimbursment formulea often encourage facilities that have less than 500 gross square feet per resident"

Fortunately, new models are emerging that are more responsive to the real needs of the frail elderly. Some are evolving from the pragmatic recognition that many of them are better served in less costly, more residential settings generally referred to as "assisted living" facilities. Others are evolving because the elderly and their families do not find the standard choices acceptable. And— in a growing number of communities — creative teams of sponsors, regulatory officials, consultants, and architects are demonstrating that there are better models.

In most cases these designs incorporate eight basic principles:

1 Maximization of privacy and resident dignity. Better semi-private design, such as the "bi-axial room" or the "shared-toilet private" are being used, bathrooms are being built so they are not visible from the corridor, individual bathing areas are used instead of gang shower/tub areas, and space is included to permit residents to personalize their rooms

and maintain connections with their past.

2 Maximization of resident independence and freedom of movement.
The spaces must be barrier free—not just for the chair bound but also for those with multiple, minor impairments. The best facilities help prolong and promote independence.

3 Recognition of the physical and mental limits of the residents.
The newer facilities recognize that travel is difficult, that chairbound residents cannot see over high bunker-

"It has been said that a society can be judged by how it treats its elderly"

like nurses' stations, that poorly designed lighting or finishes (such as striped floors that imply steps) are inhibiting, that lack of sun protection makes outdoor areas hard to use, and that residents like the security of nearby staff. Unstaffed lounges at the ends of corridors, for example, are rarely used while spaces in the center of the "action" are popular.

4 Integration into the community.
It is a myth that the aged want to be stuck out in remote pastoral settings. Most want to be in their communities near the familiar services that prolong independence and maintain their ties with their past.

5 Maximization of the access to services.
Ultimately, the quality of the support services is the most important factor in an aged person's quality of life. Therefore, leading sponsors are steadily upgrading dining, therapy, activity and other services as well as the residents' access to them. "Main Streets" of services form the core of many facilities, but in others creative approaches are being used to bring services to the resident. All leading facilities recognize that staff members who provide the services need a supportive environment as well.

6 Challenging of codes and existing models.
Most codes are not immutable if the team works to improve on the traditional models. Many of the best new buildings could not have been built without code waivers.

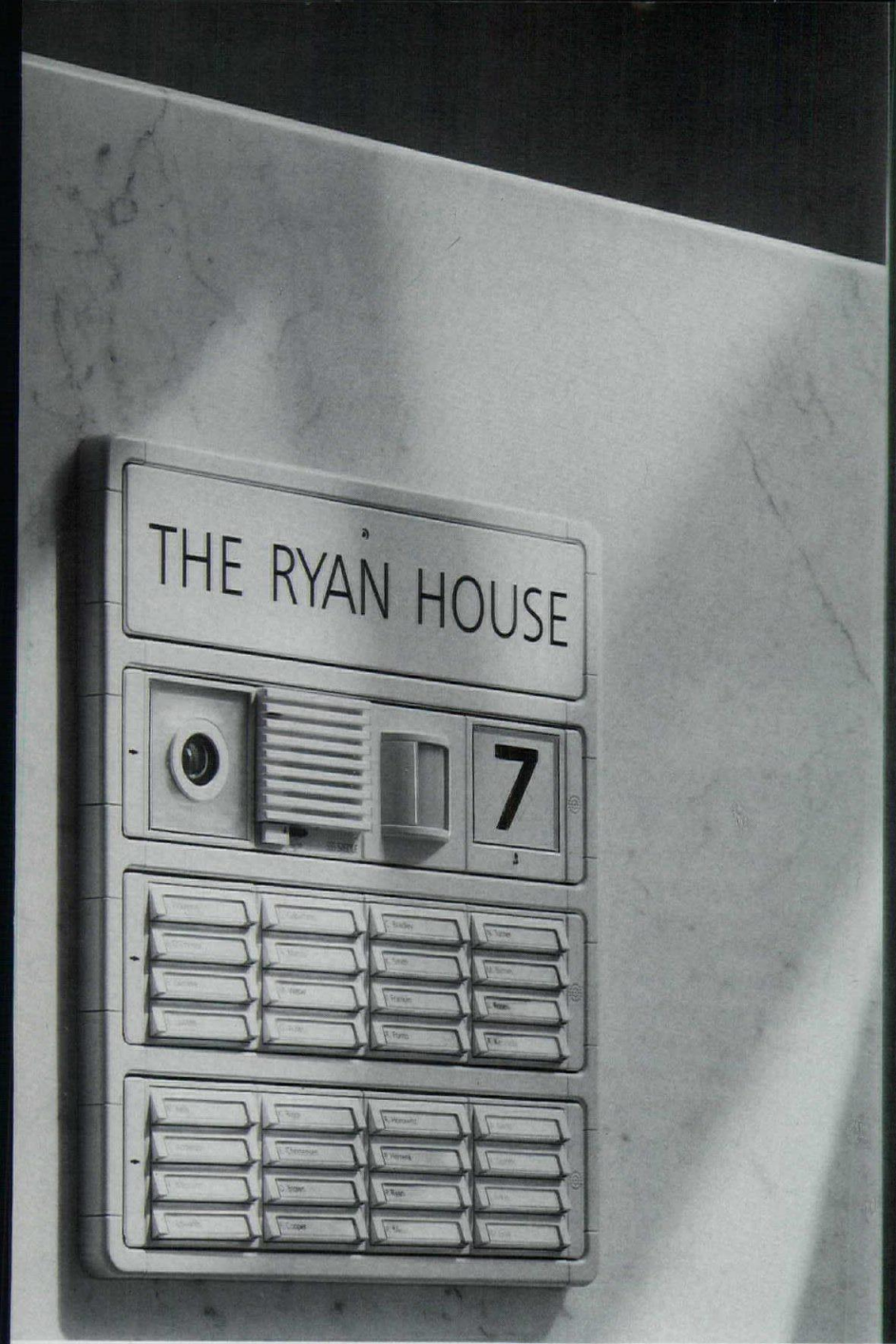
7 Recognition of the special needs of residents with dementia and Alzheimer's disease.
A lot of interesting research on this topic is beginning to be incorporated into new designs. For example, in these facilities, nursing or residential units permit subdivision into more appropriate groupings of 10 to 15 residents, cues are built in to help stimulate memory, units are designed to permit safe wandering and use of the outdoors, and attractive settings are incorporated for residents to interact with their families.

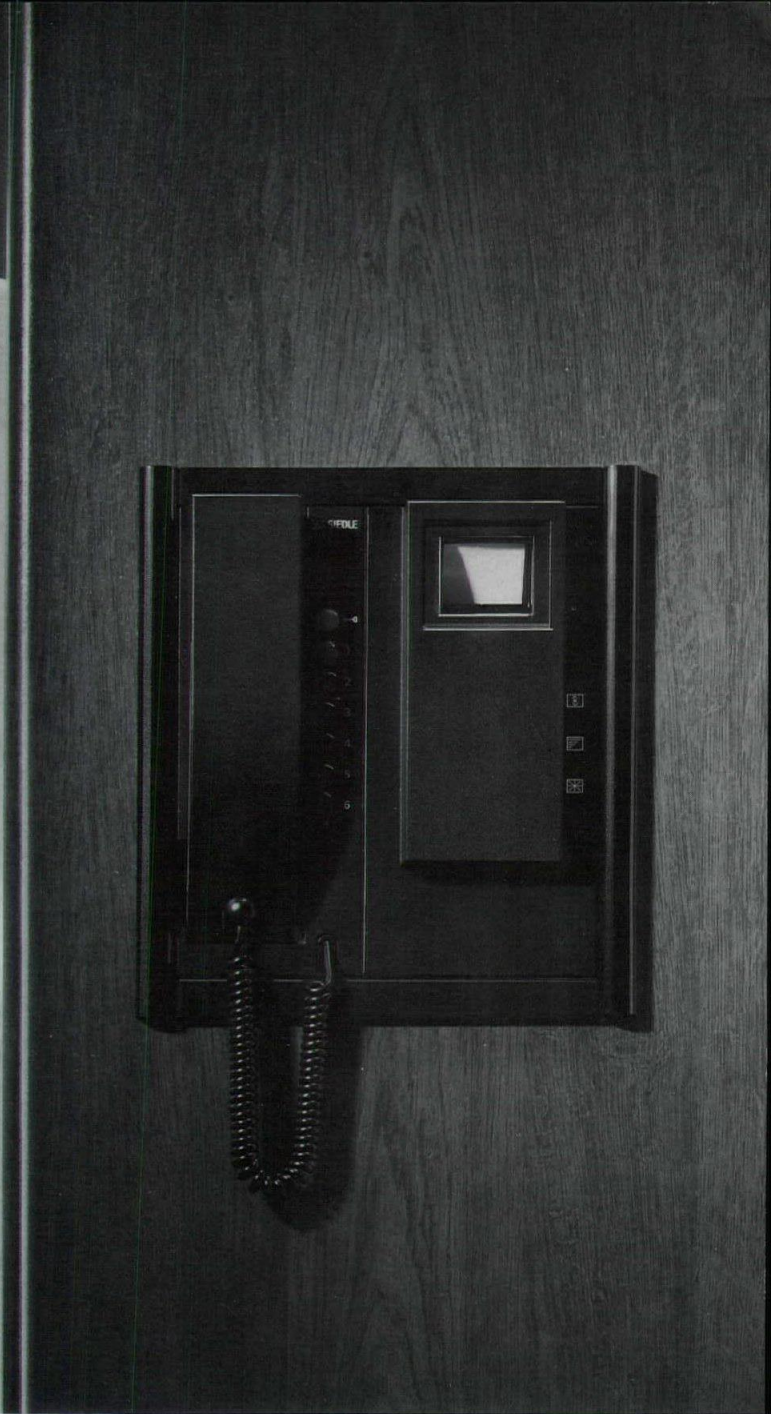
8 Recognition of the inevitability of change.
The nursing home resident is increasingly frail, but older facilities often were built for a largely ambulatory population. Dining, activity, toilet, and other facilities are too small and expensive to convert. The cost of building the extra space and flexibility early is a fraction of the cost of conversion.

Now that the growing need—combined with the decline in other building types—has focused increased attention by the design professions on facilities for the elderly, we can all hope that the architectural profession—and our clients—will build on these ideas. It has been said that a society can be judged by how it treats its elderly. If we accept this challenge, there is a lot of work to do.

Bradford Perkins

The author is a partner in the New York firm of Perkins Eastman & Partners, which has designed a number of long-term care facilities.





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Assisted Living: The U.S. Versus Europe

The following excerpt is from the new book Assisted Living Housing for the Elderly: Design Innovations from The United States and Europe (Van Nostrand Reinhold, 1993), written by Victor Regnier, Dean of the architecture school at the University of Southern California.

1 Models of Community Care

The Northern Europeans have designed a system that mixes community services with housing for the frail. They have done this by developing mixed-use arrangements, by building on air rights above other land uses, and by establishing the service house as a concept for integrated service provision within the community. Providing an extensive array of services to older people living in the surrounding neighborhood allows them to anticipate when community residents can profit from a move to the service house. Individuals are kept independent in the neighborhood for as long as possible. When they need the security of a twenty-four-hour arrangement or require intensive services on an ongoing basis, they can be assessed and moved.

Models of community care work in conjunction with housing by treating it as a service that can be prescribed when necessary. In this way, the service house does not have the stigma that we associate with an institution. The service house is a place, not only for older sick people, but for receiving help and assistance in remaining independent. This gives it an important civic function in the community, further reinforcing its identity.

2 Interdependence, Family Support and Self-Maintenance

The basic philosophy of providers is to encourage older people to do as much as they can for themselves. Frail residents are challenged to maintain their competency at its highest level. Nurses and service workers serve by encouraging them to do things for themselves, rather than by doing everything for them. This attitude suggests services should be provided in a therapeutic way that builds and maintains resident competency.

In the United States, we are recognizing that one way to reduce health care costs is to create partnerships with formal care providers that allow families to continue to care for residents by sharing caregiving responsibilities. This idea has been popularized through home care assessment models. The major benefit of these plans is the continued engagement of the family in the life of the older person. We are also recognizing how older residents can maintain their independence by helping others and staying actively involved in normal daily routines. Helping one another provides a sense of contribution that bolsters self-esteem and minimizes formal intervention.

3 Autonomy and Privacy for the Rich and Poor

The standard for housing for the frail is changing throughout the world, from one based on a hospital model epitomized by the nursing home to an idea that involves delivering health and personal care services to older people in a normal residential environment. This transition involves a fundamental shift in thinking, which balances the traditional residential qualities of privacy, autonomy, personalization, and control and choice, with the concept of safety and oversight provided by an institution. The idea of managing risk within this type of setting brings into natural balance the desire for safety and the need for autonomy.

A disturbing difference between the European projects visited and exemplary projects identified in the United States is the clear lack of public support for American models. Of the 100 site-visited European projects, 90 were designed for moderate- or low-income populations. In the second round of expert-nominated American assisted living projects (which netted 100 projects) only 10 were designed for moderate- or low-income

"Many of the ideas being actively explored in European projects are based on techniques and ideas precluded by United States regulations."

populations. We have abandoned the older frail person by providing public access only to nursing home care rather than thinking about our obligation to keep the frail out of this setting for as long as possible.

4 Respect for the Professional Caregiver
You can understand a lot about the quality of care provided in a typical facility by listening to how older people are addressed by staff. I often count how many times I hear something said that an older person finds amusing. You can also sense a dedication and concern for helping that makes you feel good and creates optimism and delight where despair and depression are often subliminally omnipresent. Here the physical environment makes only a meager contribution. It is the staff, their attitudes, and their dedication to the work which makes the difference. As a society, we have not given this high priority, while Northern European societies have degree-granting institutions and training programs that support professional approaches to care management. These societies treat caregivers for the aged with the same respect that school teachers received decades ago. Both are important jobs that any self-respecting, civilized, humane society should hold in the highest regard and do much more to support. (In Northern Europe, the level of creativity and the autonomy assumed by the lowest-level service worker is accountable to an ethical set of professional standards).

In the United States, we have created a long-term care system that is fear-based. It assumes incompetency and violation of standards are the norm rather than recognizing professionalism and reinforcing it. We police facilities, citing them for violations of standards even when these standards are not consistent with the needs, desires, and interests of older residents and their families. We have narrowed possibilities in an effort to minimize problems and as a result have thrown out positive and inventive ideas along with bad practices. We need to support professionalism, creativity, and responsibility rather than establish a set of narrow predetermined rules that denigrate and dehumanize the caregiver and the older person.

5 Regulations that Encourage Innovation, Experimentation, and Cost Containment
Most new European housing models dealing with the needs of the chronically mentally and physically frail older person are experimental. Each building is viewed as a potential experiment for testing new ideas and best practices. Many of these buildings are formally evaluated and information about success and failures flow back into the system to inform practice the next time a building is initiated.

Furthermore, regulations and standards, which could be viewed as stringent even by United States standards, are flexible enough to be challenged, interpreted, and pursued in a variety of different ways. Europeans are experiencing the same economic malaise as the United States and must deal with a fixed sum of resources. In developing new models, two major criteria are applied to all new project designs.

1. Will the new idea contain costs more effectively?
2. Will it provide a higher level of residential satisfaction to residents?

If a preliminary idea meets these two criteria, then it is deemed worthy of further exploration.

Many of the ideas being actively explored in European projects are based on techniques and ideas precluded by United States regulations, and if pursued in this country they would be considered illegal. We need to examine the purpose and rationale behind building codes, zoning codes, licensing requirements, and state-mandated regulations. Instead of trying to anticipate the myriad of problems and possibilities that exist, we should establish a performance standard which encourages innovation and serves the best interest of residents and their families.

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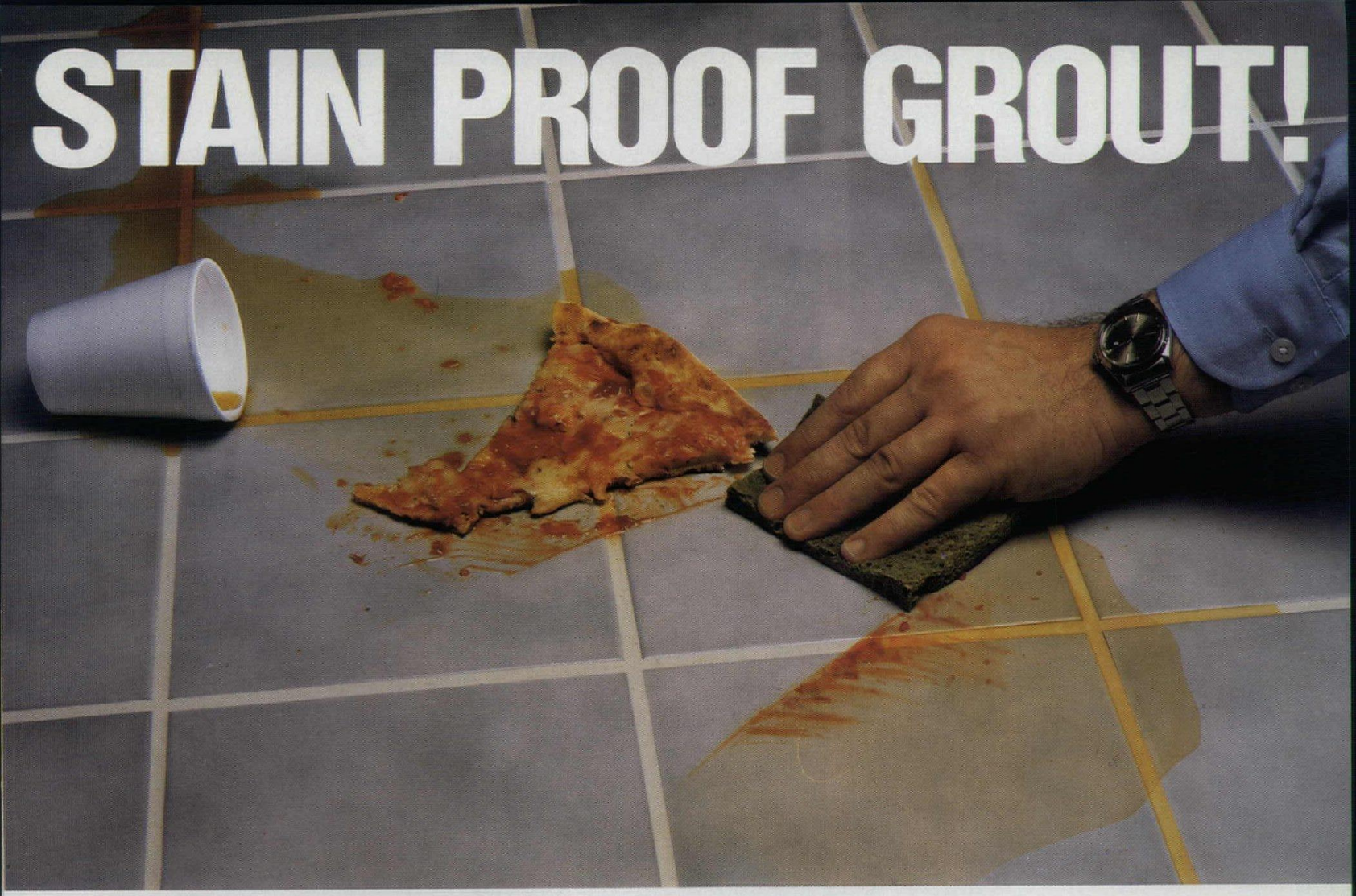

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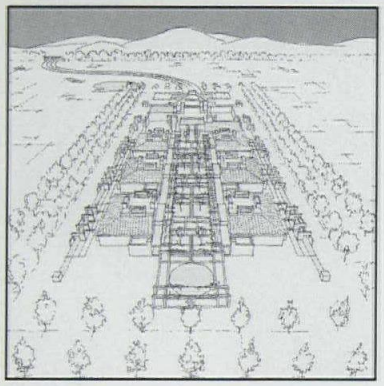
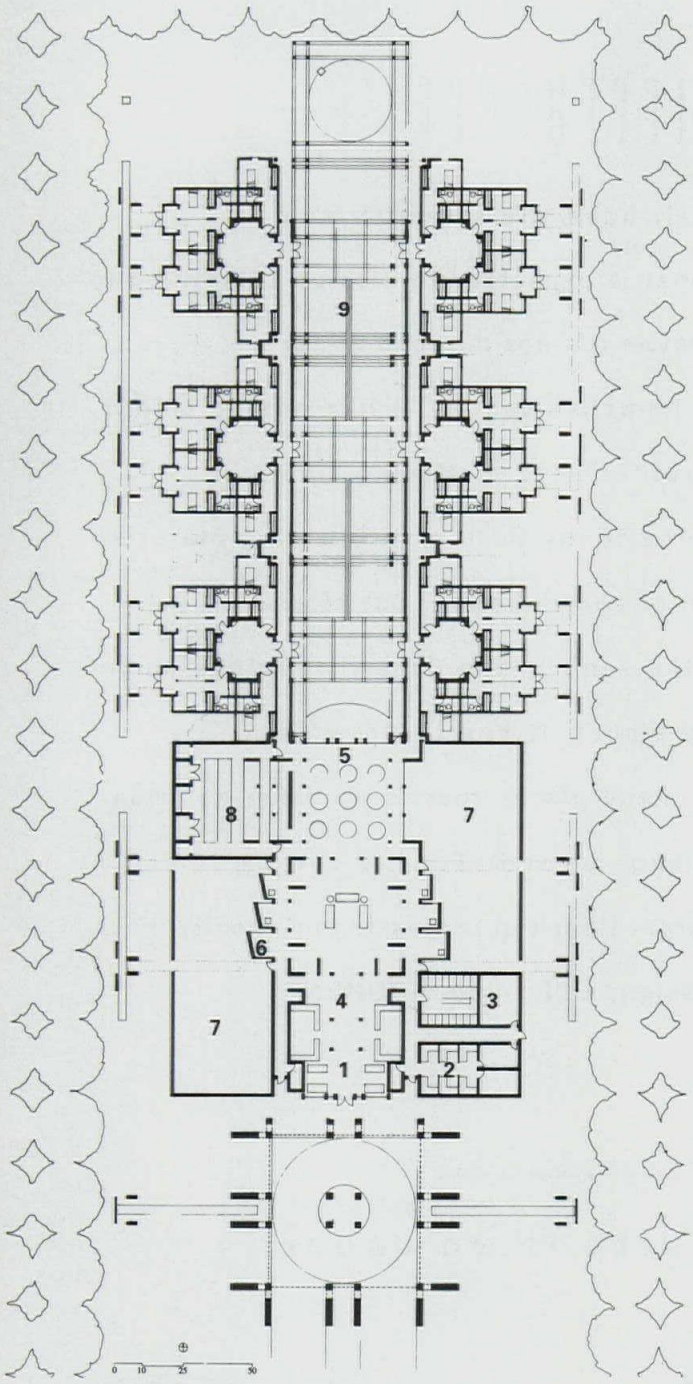


Perspective

Society of Singers Desert Home

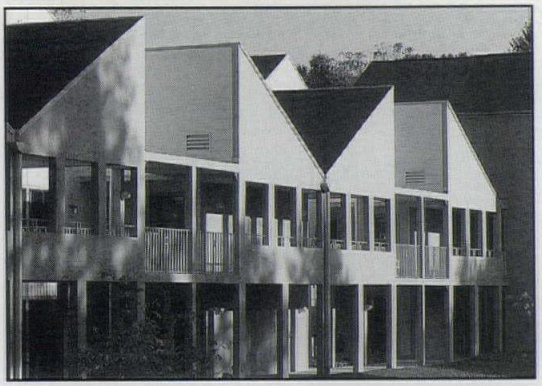


1 ENTRANCE
2 ADMINISTRATION
3 HOUSEKEEPING
4 LIVING ROOM
5 DINING ROOM
6 MUSIC ROOM
7 COURTYARD TENT AREA
8 KITCHEN
9 RESIDENTIAL COURTYARD

GROUND FLOOR PLAN

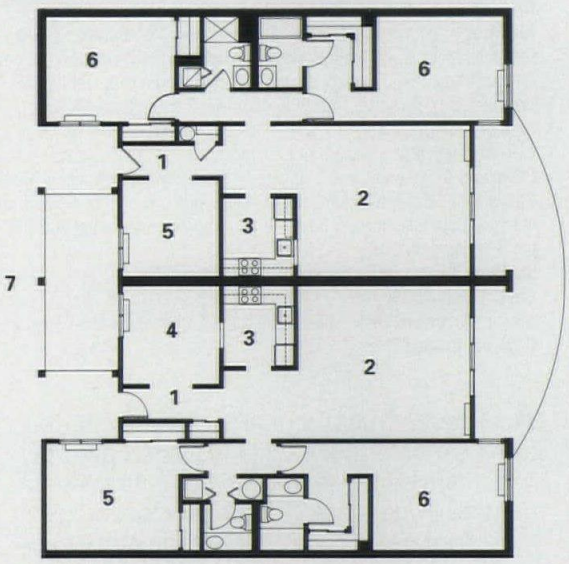
Project: Society of Singers Desert Home, Laughlin, NV.
Architect: Bobrow/Thomas & Associates (BTA, Inc.), Los Angeles, CA (Michael Bobrow and Julia Thomas, *principals-for-design;* James Auld and Cheryl Kane, *design team*).
Client: Society of Singers.
Program: Residential and communal spaces for retired singers; future plans call for a skilled nursing facility and a Wellness Unit.
Building Area: (net/gross, square feet) 25,500/30,000.
Cost: $5.2 million.
Major Materials: Concrete block with partial plaster, wood frame roof structure, metal roof, ceramic tile, hardwood floors.
CAD-developed? No.

Architect's Statement: The intention of the Desert Home is to provide an independent living situation that combines adequate personal territory with accessible semiprivate spaces and common social areas. Phase one of the project includes six residential houses organized by a central, exterior courtyard and anchored, to the south, by a main house. Each of the shared houses consists of a cluster of two single rooms and two double rooms, each with access to a private outdoor garden and to a shared living room. Thick-walled forms, cradling furniture and momentos, rise to create light monitors with clerestories on the north and east elevations. The walled forms mark the center of each shared house, and filter natural light into the living rooms. Common social and public areas, including a drop-off area, reception, living room, dining room, library, rehearsal rooms, recording booths, music rooms, and laundry facilities, are in the south end of the complex. The exterior spaces and landscaping are an important part of the design. An arcade traces the building's edges with trellis work. Light cable structures traverse the expansive courtyard at its access points to provide shade from the hot desert sun. Flowing from sources housed at the perimeter of the building site, water is intended to serve as a visual link between private and public spaces.



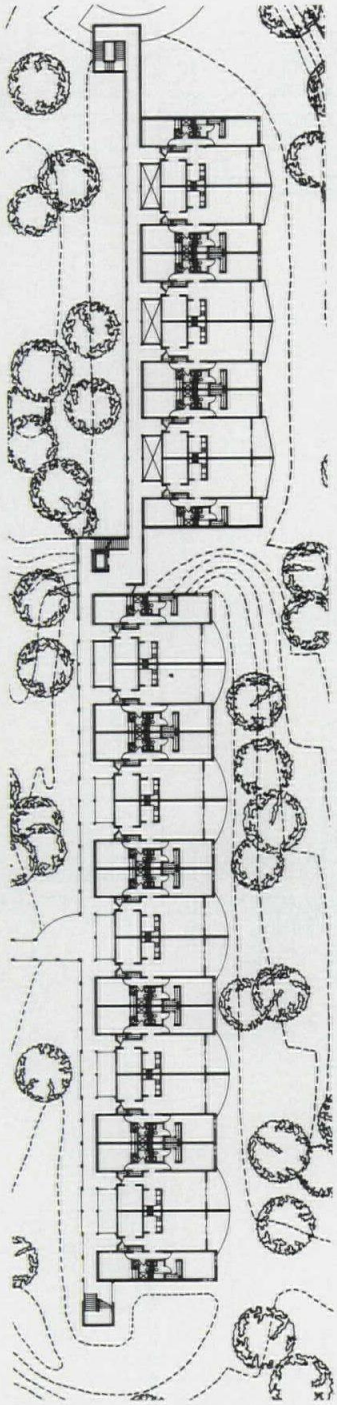
Entry

Cathedral Village Country Apartments



TYPICAL UNIT

N ↘ 20'/6m



N ↘ 40'/12m

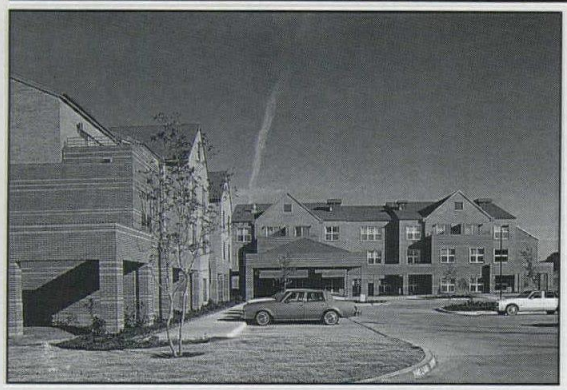
GROUND FLOOR PLAN

1 ENTRY HALL/FOYER
2 LIVING ROOM
3 KITCHEN
4 DINING ROOM
5 STUDY/DEN
6 BEDROOM
7 WALKWAY

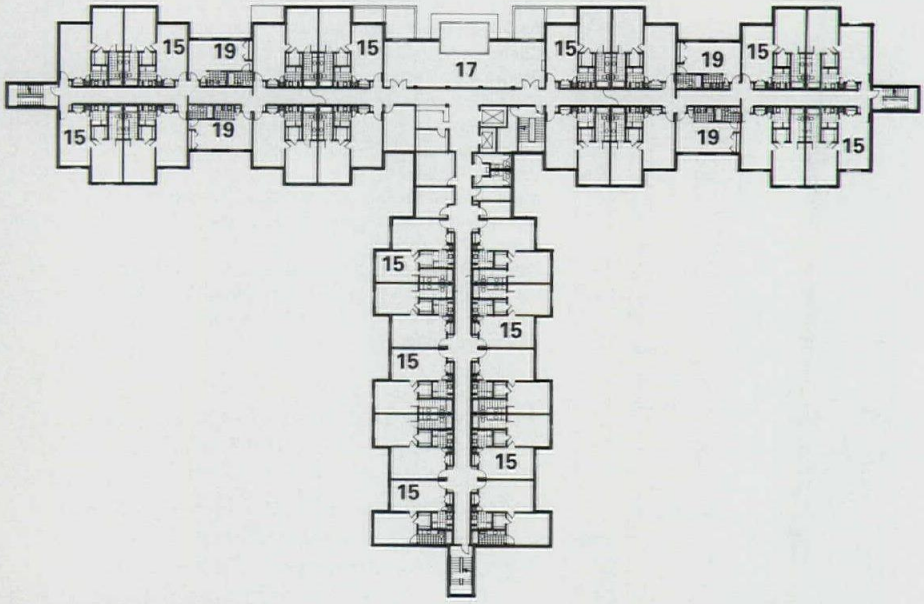
Project: Cathedral Village Country Apartments, Philadelphia, PA.
Architect: Dagit Saylor Architects, Philadelphia, PA.
Client: Cathedral Village, Philadelphia, PA.
Program: Addition consisting of 32 two-bedroom apartments connected by exterior corridors; each has a small deck or terrace.
Site: 39 acres.
Building Area: 48,000 square feet.
Cost: $4,692,000.
Major Materials: Masonry bearing walls, wood truss flooring and roof systems, wood stud and gypsum board partitions, aluminum windows, and wood siding.
Consultants: Kamariotis & Associates, structural; Waxman-Lit Consulting Engineers, mechanical/electrical; Coe Lee Robinson Roesch, Inc., landscape.
CAD Developed: Yes.

Architect's Statement: Originally constructed in the early 1980s, Cathedral Village is a 277-unit residential community offering complete continuing care services. The 32-unit addition is designed to be harmonious with the existing complex, employing the same exterior corridor system and materials. The new facility is organized in two clusters of apartments that step down the sloping grade. An elevator/stair core links the two-story structures. Units on the upper floor have a high ceiling and a skylight in the living room area. All units are organized around an entry corridor and vestibule, giving distinct order to the various rooms. Flexible room configurations were designed to allow for individual preferences. The dining area, for example, may be open to the kitchen or walled off to serve as a study.

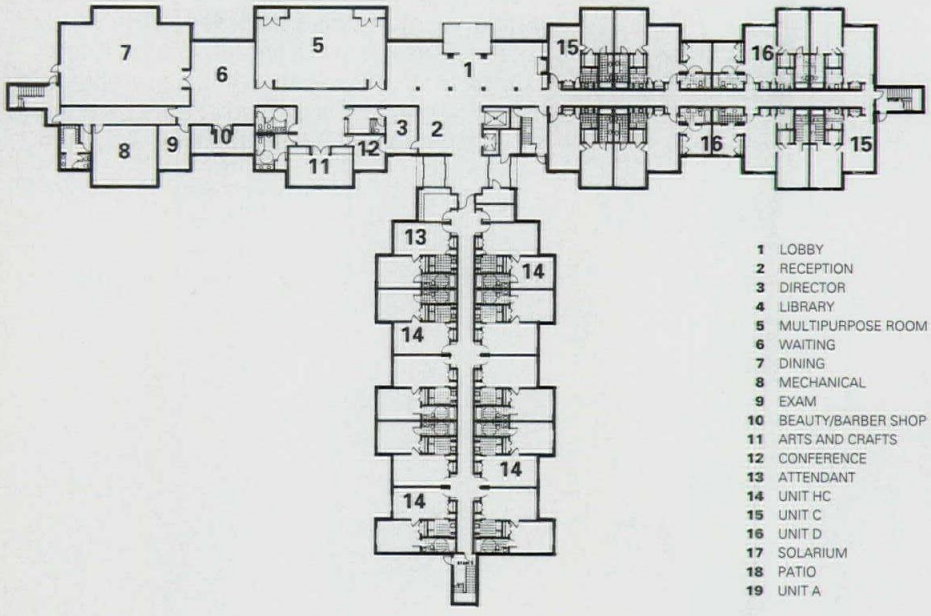
Presbyterian Village North



Exterior View



SECOND FLOOR PLAN



1 LOBBY
2 RECEPTION
3 DIRECTOR
4 LIBRARY
5 MULTIPURPOSE ROOM
6 WAITING
7 DINING
8 MECHANICAL
9 EXAM
10 BEAUTY/BARBER SHOP
11 ARTS AND CRAFTS
12 CONFERENCE
13 ATTENDANT
14 UNIT HC
15 UNIT C
16 UNIT D
17 SOLARIUM
18 PATIO
19 UNIT A

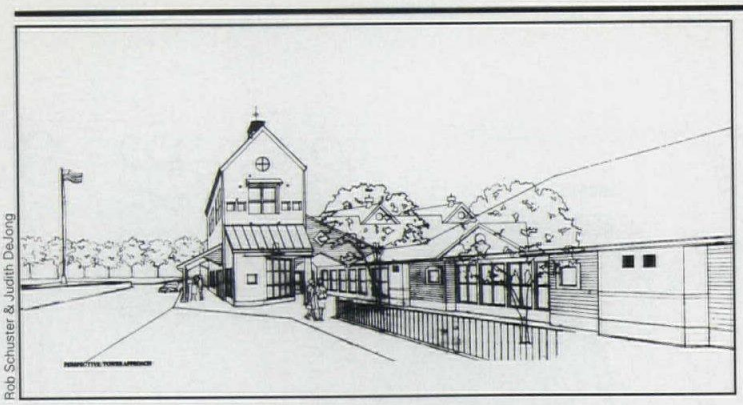
FIRST FLOOR PLAN

N ↑ 40'/12m

Project: Presbyterian Village North, Dallas, TX.
Architect: Henningson, Durham & Richardson, Inc., Dallas, TX (Merle Bachman, *principal;* Bernie Bortnick, *design architect;* Dan Hursin, *project architect;* David Rouw, *electrical engineer;* Ken Gill, *mechanical engineer;* Rich Pruscha, *structural engineer;* Pamela Caubarreaux, *interior designer;* Vince Ellwood, *landscape architect*).
Client: Presbyterian HealthCare System.
Program: A personal care facility for a retirement community in North Dallas, including apartments, duplex units, and a commons area. Site planning and development informally segregates residential housing areas by level of care.
Building Area: (net/gross, square feet) 59,400/75,240.
Cost: $77/sf (1989).
Major Materials: Brick, steel studs, steel frame, aluminum windows.
CAD-developed? Yes.

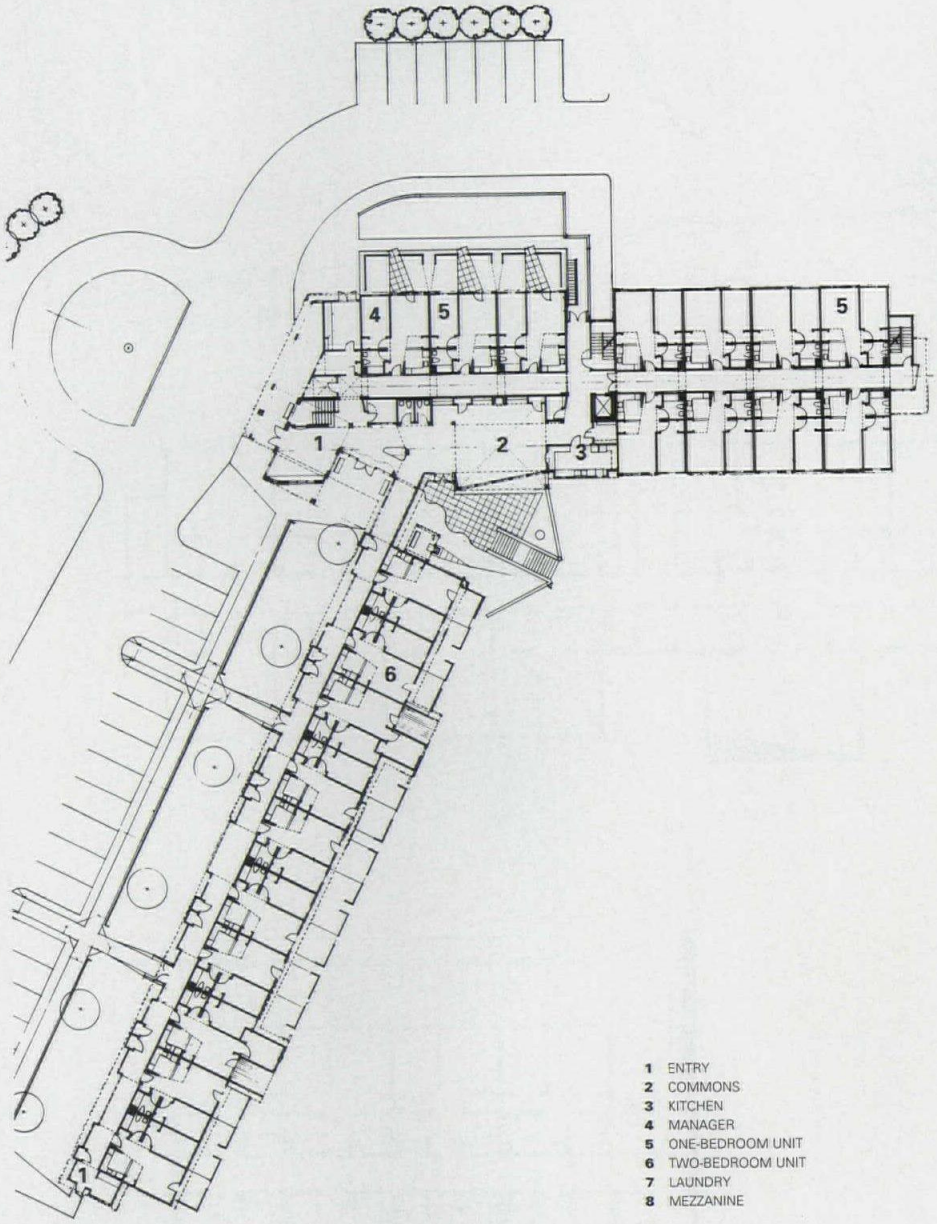
Architect's Statement: The 78-unit site features a master planned landscaped promenade flanked by personal care units and congregate living units. A large, enclosed "great room" intersects the promenade at its midpoint and serves as a major lobby and reception space. A covered walkway provides an enclosed area for residents between the "great room" and the community building, to be developed later. The design resembles a cluster of townhouses with balconied and arbor structures and emphasizes accessibility. Living units are designed for the handicapped and aged and include efficiency apartments and one- and two-bedroom units. Each unit contains a bedroom, a kitchen/dining area, a bathroom, and storage. Larger units include a separate living area. Each unit has emergency call buttons, a communication console, and heating and cooling controls. Each floor provides casual meeting spaces close to the elevators. The ground floor congregate spaces are in a central zone. The common area, centrally located on the ground floor, houses the beauty and barber shop, a lobby and lounge area, a library, an arts and crafts room, laundry and housekeeping areas, an exam room for minor medical care, an 80-seat dining room, and a solarium with a garden.

Canal Town Village



Rob Schuster & Judith DeJong

Perspective of Tower Entry



1 ENTRY
2 COMMONS
3 KITCHEN
4 MANAGER
5 ONE-BEDROOM UNIT
6 TWO-BEDROOM UNIT
7 LAUNDRY
8 MEZZANINE

N ↗ 32'/6m

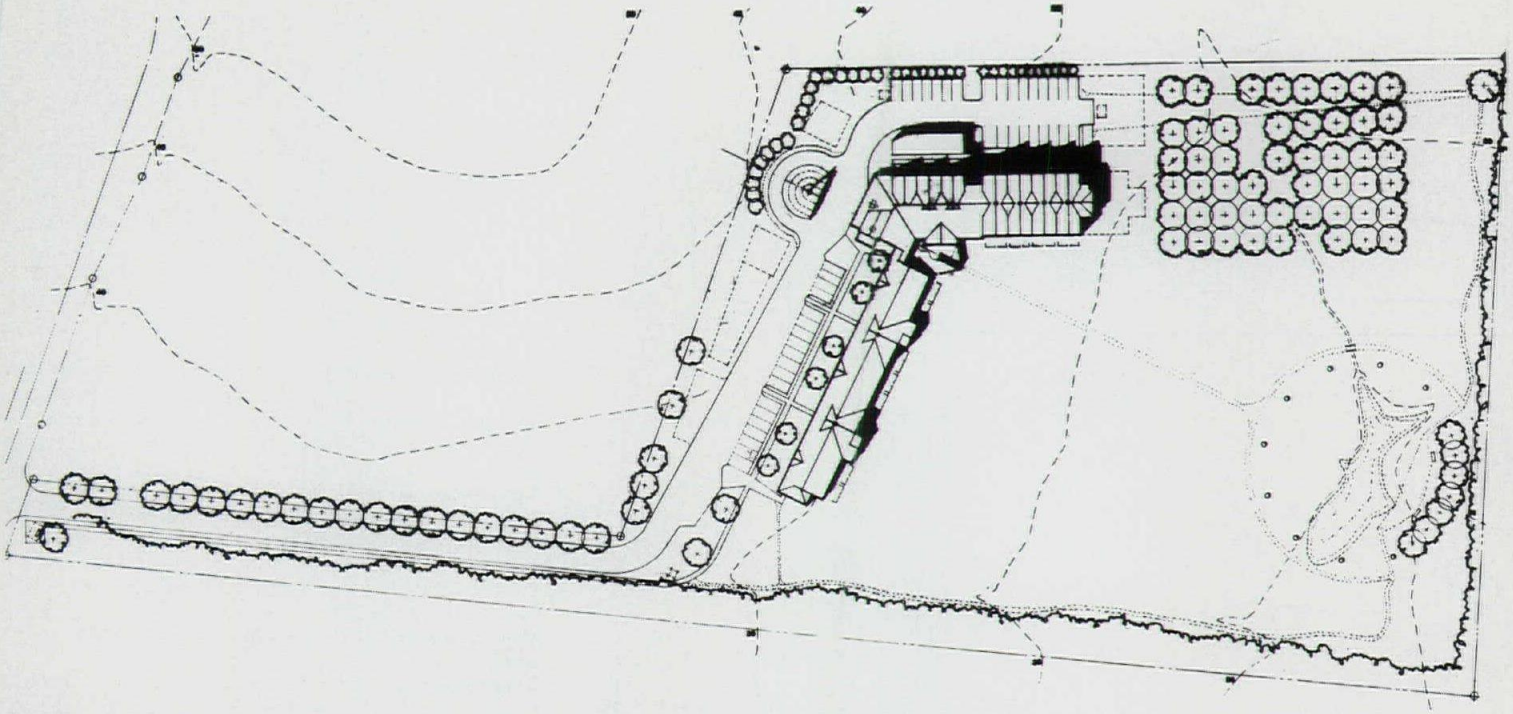
FIRST FLOOR PLAN

Project: Canal Town Village Senior Citizens Facility, Chesapeake City, MD.
Architect: John Lucas, Architect, State College, PA (John Lucas, Veronica Burns Lucas, Donald Kunze, Judith DeJong, Robert Schuster, *design team).*
Client: Canal Town Village, Inc.
Program: 40 senior citizen apartment units with a multipurpose hall, healthcare, nutrition and hygiene offices, and support facilities for recreation, laundry and storage.
Building Area: (net/gross, square feet) 27,500/35,000.
Cost: $60/gsf (est. 1992).
Major Materials: Unit masonry base, wood frame structure, wood siding, stucco.
Consultants: Stuart Hershey, development coordinator; Parfitt-Ling structural, mechanical, and electrical; Duffield Associates, geotechnical engineering; Windward Associates, site engineering.
CAD-developed? No.

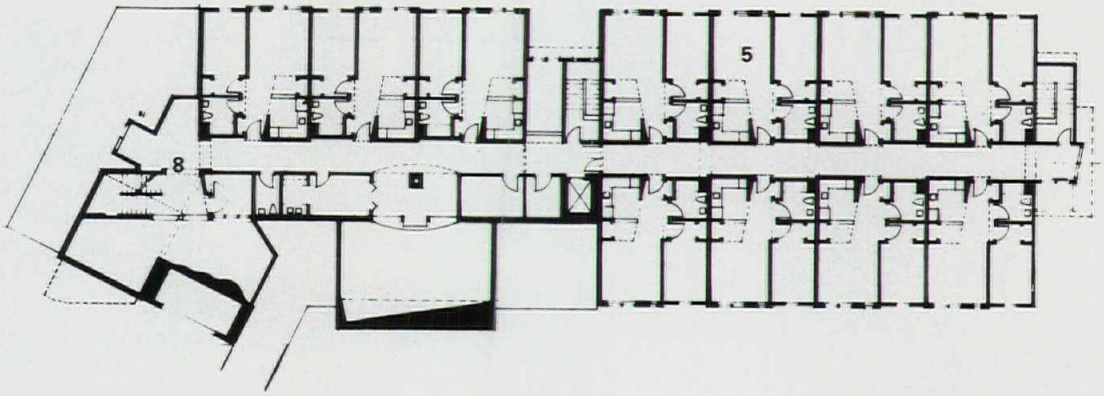
Architect's Statement: This project accommodates people from the eastern shore town of Chesapeake City and its rural surrounds. The design attempts to project an atmosphere of restraint, straightforwardness, and good will toward its residents. Both client and architect wanted to provide a comfortable and affordable dwelling place that goes beyond the norms of senior citizen housing, a place where residents can continue to live independently.

The facilities are modest but adequate, with forms and detailing reminiscent of the area's traditional buildings. The project resembles a village, with individual houselike structures in a coherent ensemble. The two main housing blocks come together in a towered structure that holds the entrance, management, meeting room, terrace, and other support facilities. The tower, a landmark and entry point, is also a "time piece" with detailing that refers to mythologies of passage, eternity, and the everlasting. Most of the site is to remain an open meadow, with exercise and walking paths to landscaped nodes on the perimeter of the property.

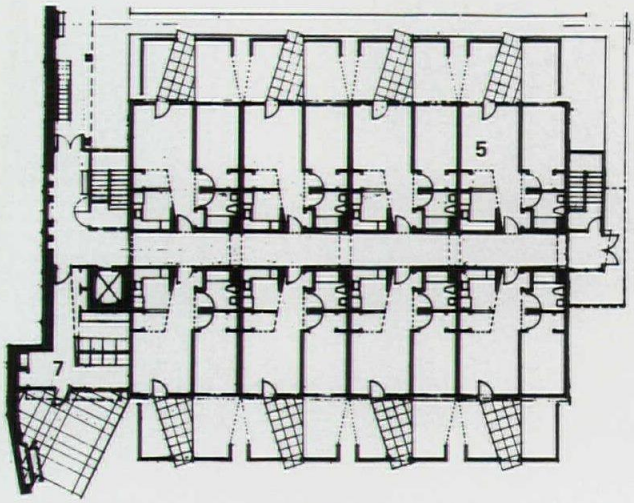
The main rooms of each unit are designed for maximum light and views, and are organized for easy circulation. Each unit is compact, yet seems open to the outdoors. Corridors are designed to encourage dialogue; they are metaphorical village streets.



SITE PLAN N 100'/30m



SECOND FLOOR PLAN



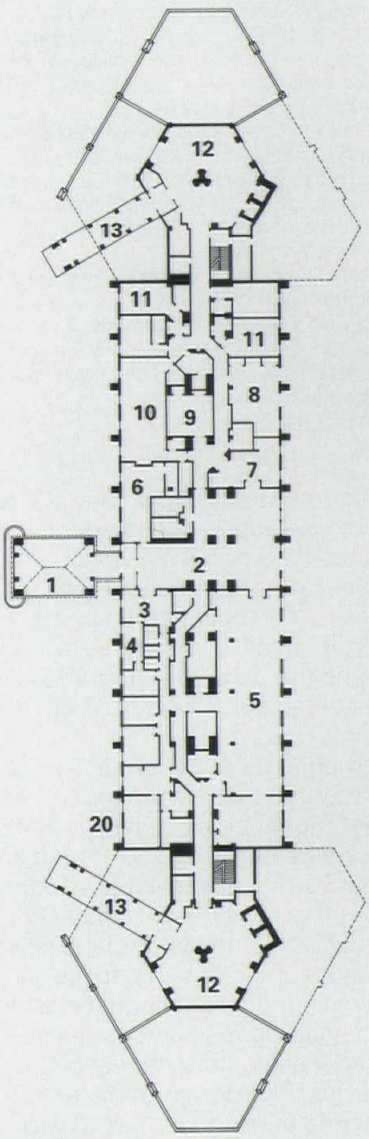
LOWER LEVEL FLOOR PLAN N 32'/6m

Rendering

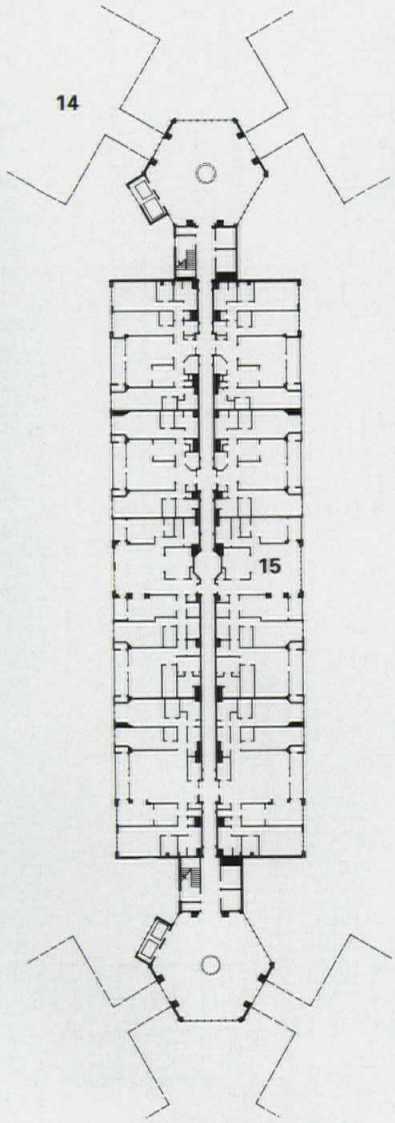
University Village Retirement Community

Project: University Village Retirement Community, Charlottesville, VA.
Architect: Mitchell/Matthews & Associates, Charlottesville, VA.
Client: University Village, Inc.
Program: Phase one of a $50-million, 700,000 sq.ft. luxury retirement community that responds to the strong architectural heritage of the area. The project is to be constructed in five phases.
Building Area: (net/gross square feet) NA/120,000.
Cost: $12,000,000 (1992).
Major Materials: Concrete, structural steel, brick, EIFS, standing seam metal roof vinyl clad doors and windows, steel stud framing, gypsum board, carpet, tile.
Consultants: Tadjer Cohen, structural; 2RW Consulting Engineers, mechanical/electrical; The Cox Company, civil.
CAD-developed? No.

Architect's Statement: University Village is located on a hilltop site in Albemarle County, Virginia, just outside the historic city of Charlottesville. The first phase, completed in 1991, includes forty-six luxury one-, two- and three-bedroom condominiums on the upper five floors. Administrative offices, library, guest rooms, card rooms, bank, lounges, crafts room, gift shop, sales office, auditorium and lobby are located on the first floor. Parking, resident storage, and mechanical and electrical spaces are on the lower level. (Elevator cores are located in the hexagonal ends of the building, where future wings will be added.) Located within sight of Monticello and the Rotunda at the University of Virginia and surrounded by a number of Jeffersonian structures, the design of this Neo-Classical building was strongly influenced by its context: brick was selected as the main cladding material, with dark colored mortar at the first floor; the top floor of the building was clad in white EIFS with a two-inch standing seam, patinated-green metal roof.



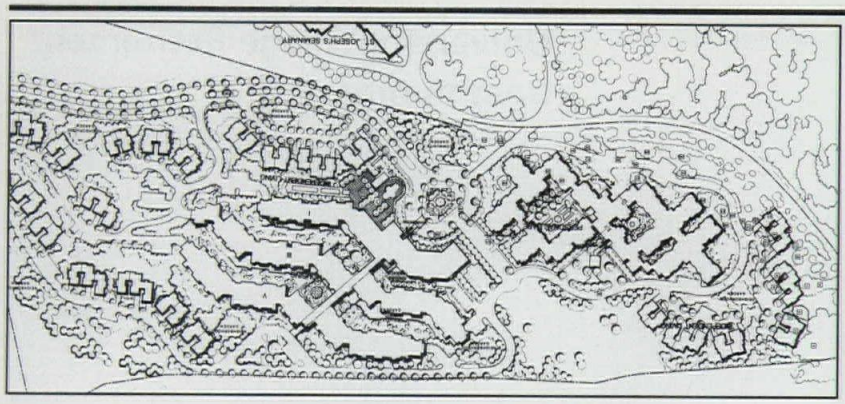
FIRST FLOOR PLAN



SIXTH FLOOR PLAN

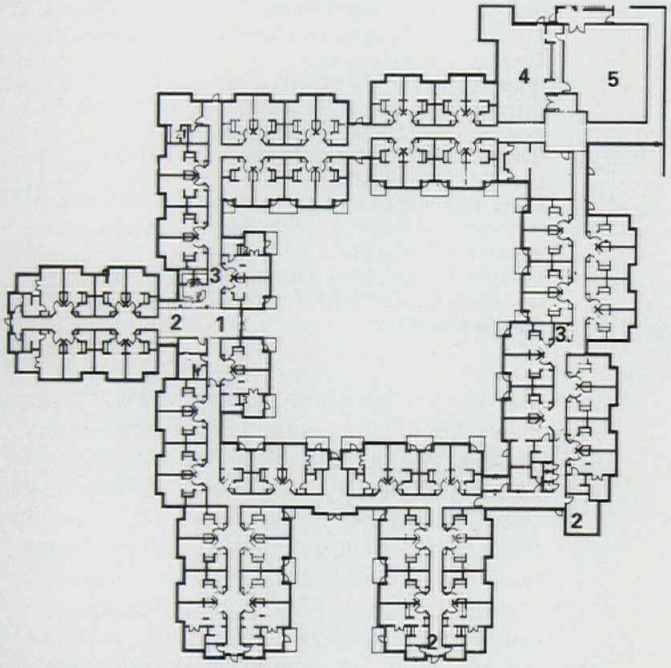
1 PORTE COCHÈRE
2 LOBBY
3 RECEPTION
4 ADMINISTRATIVE OFFICE
5 MULTIPURPOSE ROOM
6 CONVENIENCE STORE
7 LIBRARY
8 ARTS & CRAFTS ROOM
9 CONFERENCE ROOM
10 GAME ROOM
11 GUEST ROOM
12 CIRCULATION CORE
13 COVERED WALK
14 FUTURE PHASE
15 LIVING UNIT

N ↘ 40'/12m



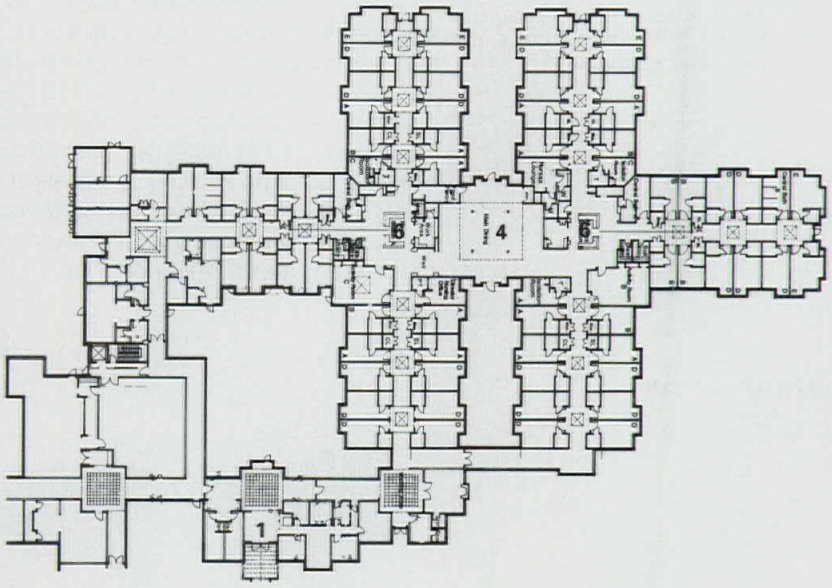
Site Plan

The Forum at Rancho San Antonio



PERSONAL CARE FLOOR PLAN

1 LOBBY
2 LOUNGE
3 ATTENDANT'S STATION
4 DINING
5 KITCHEN
6 NURSE'S STATION



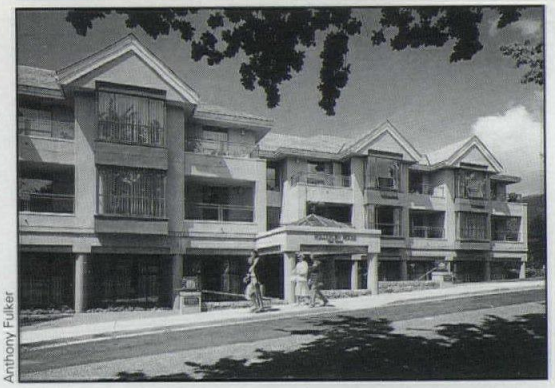
SKILLED NURSING FLOOR PLAN

N 80'/24m

Project: The Forum at Rancho San Antonio, Cupertino, California.
Architect: Hardison Komatsu Ivelich & Tucker Architects, San Francisco (George Ivelich, *principal in charge;* Gerry Tierney, *project architect;* Anne Cervantes, Tom Pinkowski, John Stromwall, Alice Sung, *design team;* Tom Brutting, *construction administrator*).
Client: The Forum Group, Indianapolis, Indiana.
Program: Develop a 75-unit personal care facility and a 99-bed skilled nursing facility to support over 600 elderly people.
Building Area: (net/gross, square feet) 652,250/734,000.
Cost: $65.00/sf (apartments), $83.00/sf (villas), $75.00/sf (community facilities), $105.00/sf (health care center), $79.00/sf (average cost, including site improvements).
Major Materials: Concrete and wood-frame, stucco veneer, concrete tile and metal roofing, metal-framed windows.
Consultants: Barbara Vessels, Walter Arnold, and Forum Group, interiors; Brian Kangas Foulk, civil; Robinson Meier Juilley & Associates, structural; Montgomery & Roberts, mechanical; Chamberlain/Painter, electrical; Robert LaRocca & Associates, landscape.
CAD-Developed? Yes.

Architect's Statement: This new community for the elderly houses up to 600 residents in its stucco and red-tiled buildings, which are terraced into the natural contours of the rolling 54-acre site. The built portion of the site steps up from small, one-story detached structures around the perimeter, to three-story apartments over underground parking bays.

The major components of the project are 60 villas, intended for the most independent residents; 259 apartments in five buildings; a 75-unit personal care center designed around a landscaped courtyard; and a 99-bed skilled nursing facility. Innovative design solutions resolved the specialized needs of the elderly in a setting with steep grades. An enclosed pedestrian spine connects the central cluster of six buildings enabling residents to reach the common facilities without the need for stairways or ramps. The design of the assisted living and skilled nursing facilities maintains a residential ambiance; special lighting, handrails, and seating are designed to eliminate the institutional quality inherent in many elderly facilities.

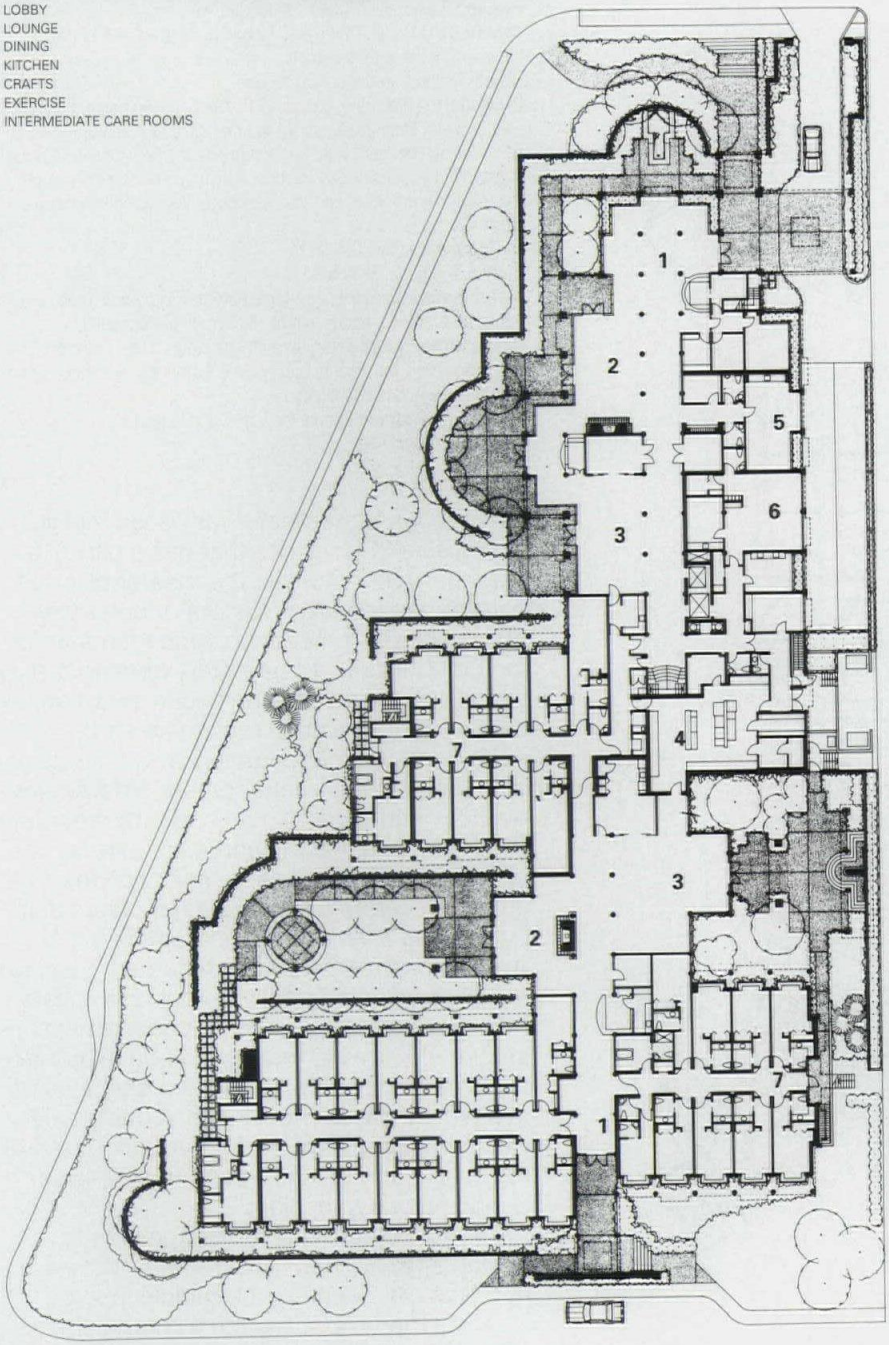


Anthony Fulker

Entrance to Intermediate Care Facility

Hollyburn House

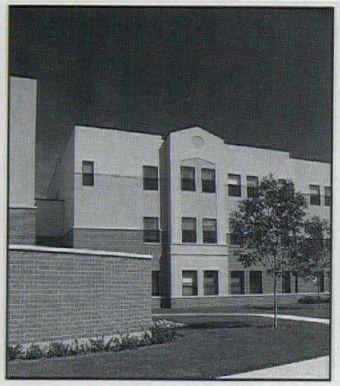
1 LOBBY
2 LOUNGE
3 DINING
4 KITCHEN
5 CRAFTS
6 EXERCISE
7 INTERMEDIATE CARE ROOMS



FIRST FLOOR PLAN

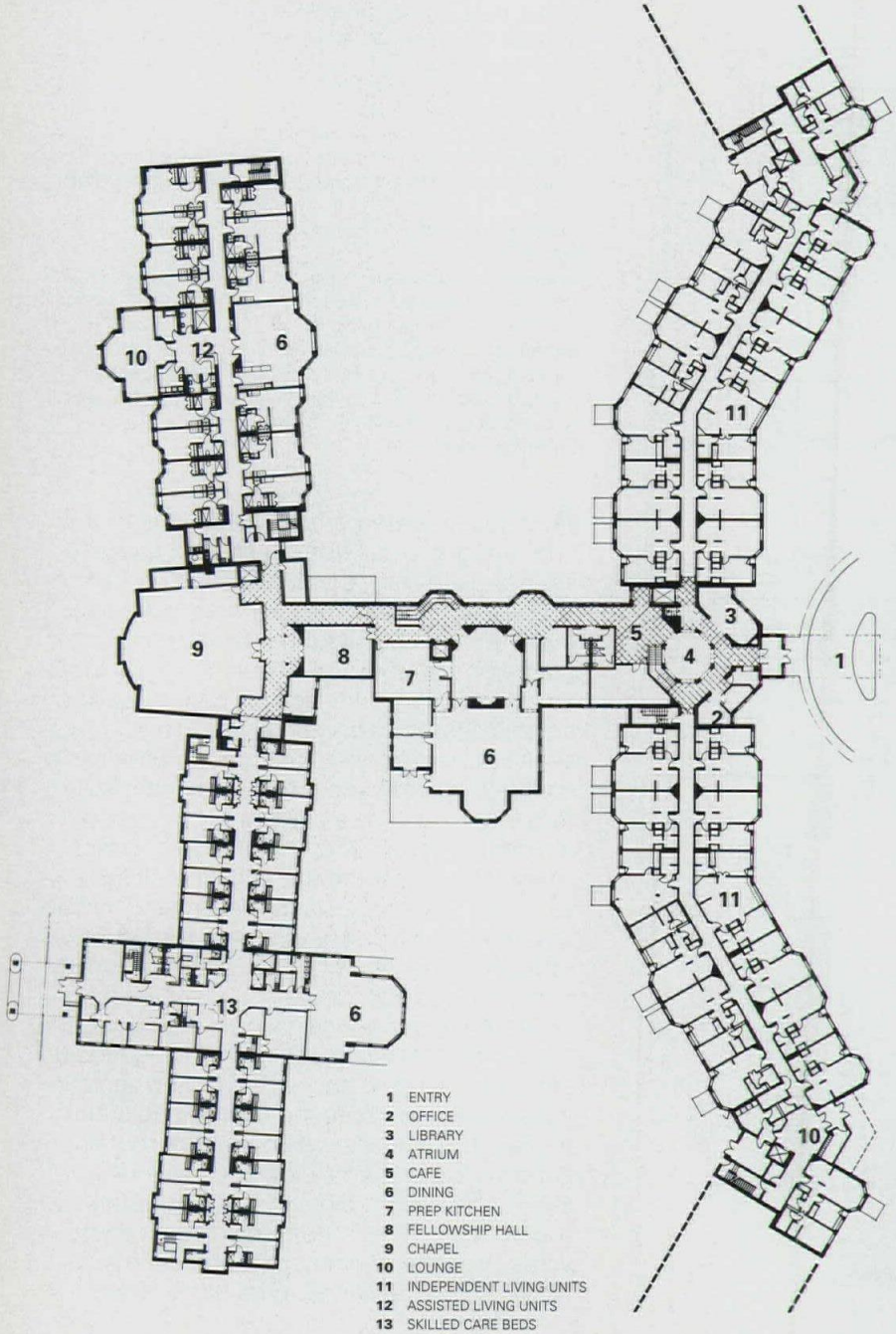
Project: Hollyburn House, West Vancouver, British Columbia.
Architect: Neale Staniszkis Doll Adams Architects, Vancouver, British Columbia (Jerry Doll, *partner in charge,* Tom Staniszkis, Larry Adams, Jones Lee, *project team*).
Client: Laing Property Corporation, Vancouver, British Columbia (Robin Cordwell, *president,* Alec Caruth, *vice president*).
Program: Design a project to offer a range of living options for seniors' comprising 66 self-contained apartments and a 36-unit care centre.
Building Area: (net/gross, square feet) 60,500/80,650.
Cost: $87/gsf (1988 est.)
Major Materials: Basement to second floor is concrete with steel stud infill, third floor and roof are wood frame construction; exterior is stucco with aluminum windows.
Consultants: Tamm Tacy Engineering, structural; Alexander Boome Consulting Engineering, mechanical; Schenke/Bawol Engineering, electrical; Guzzi Perry Wuori Landscape Architecture, landscape architect, Centre Point Construction, contractor.
CAD-developed? No.

Architect's Statement: This was one of the first facilities in western Canada to merge intermediate care, seniors' residences, and support amenities. The client requested an unpretentious building that would blend into the neighborhood. The project is ideally located close to a seniors' activity center, library, aquatic center, parks and shops. To achieve a sense of permanence, the ground floor has a concrete column and articulated beam system that serves as a podium for the upper residential floors. Internally, these columns define the circulation routes and partially enclose the dining and lounge areas. The surrounding granite walls and peak-roof forms reflect the neighborhood character. To create a friendly and supportive non-institutional environment, care was taken in designing the interior and exterior spaces, including fireside lounges, dining rooms, a health club and clinic, beauty salon, meeting rooms, and crafts rooms. The landscaped courtyards contain gazebos, arbors, small fountains, viewing areas, and garden plots that are accessible to the disabled. There are three distinct courtyards that offer quiet secure places to sit or stroll and are designed to be barrier free.



View of Exterior

Franciscan Village



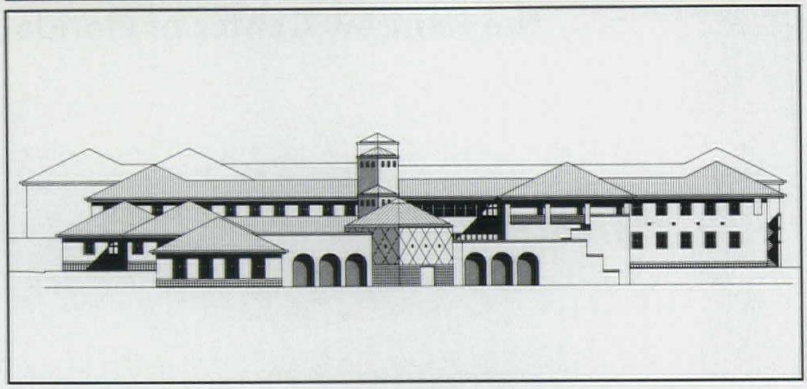
FIRST FLOOR PLAN

Project: Franciscan Village, Lemont, Illinois.
Architect: O'Donnell Wicklund Pigozzi and Peterson Architects, Incorporated, Deerfield, Illinois.
Client: Franciscan Sisters of Chicago.
Program: In phase one, provide a 150 bed nursing home; in phase two, provide 78 independent living units, 50 coach homes, and a senior living community center; and in phase three, provide 72 independent living units, 30 assisted care living units, The Village Inn Adult Day Care Center, and the Franciscan Village Administrative Offices.
Building Area: 331,000 sq.ft.
Cost: $26 Million, $78.55/sq.ft.
Major materials: Brick, split-face block, EIFS, drywall, precast plank floors, steel frame, wood framing, masonry bearing walls.
Consultants: Branecki-Virgilio and Associates, civil; David McCallum and Associates, landscape; Dickerson Engineering, electrical; Brian Berg and Associates, mechanical.
General contractor: Pepper Construction Company.
CAD-developed? Yes.

Architect's Statement: Franciscan Village occupies a 33-acre site that has a park-like feeling. Architecturally, the master-planned community features clusters of one-story coach homes, a three-story independent living unit building, a three-story nursing facility, and a low-scale community center containing chapel, dining, and recreation areas.

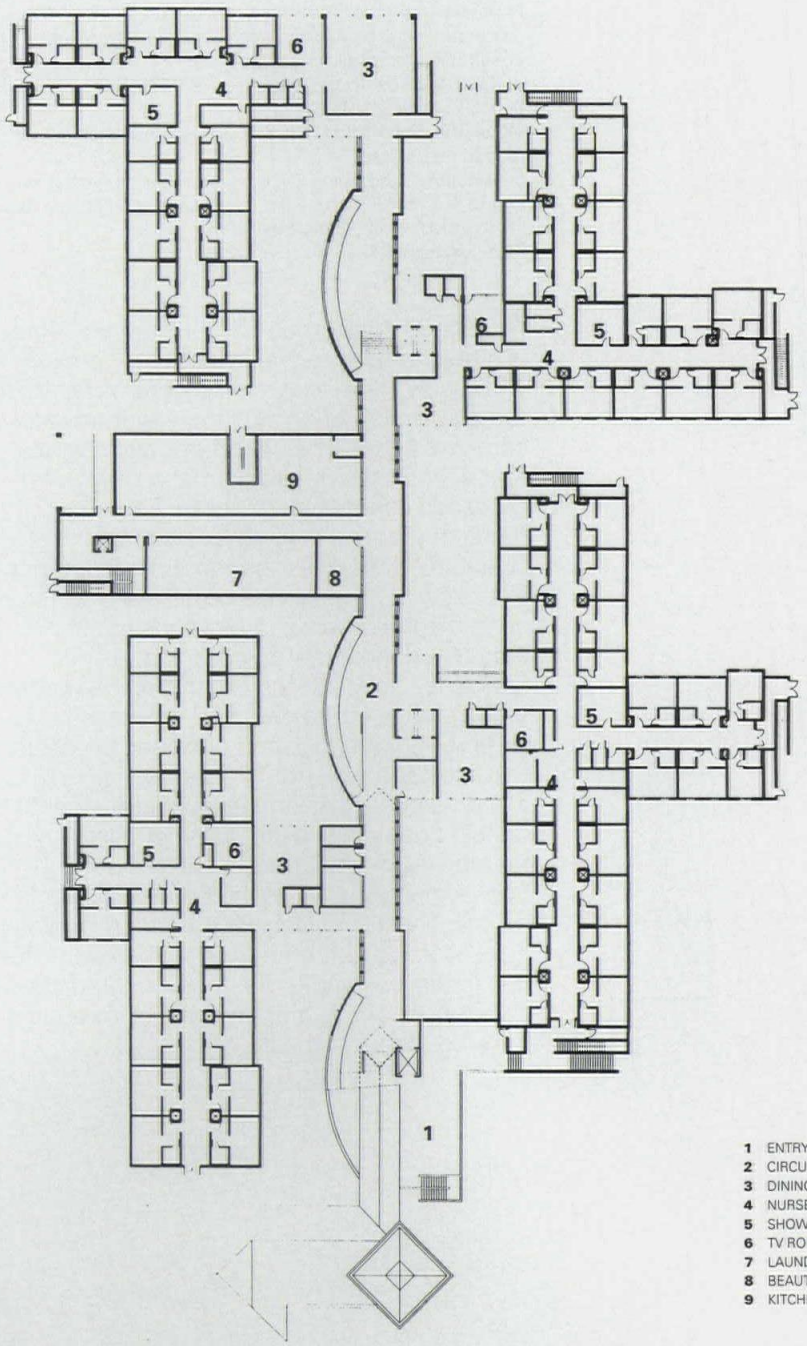
The primary architectural goal was to design a village within a village, where different levels of living function independently, yet blend together cohesively as integral "parts of the whole." This seamless, transitional design approach caters to the needs of older adults by offering a variety of living options. Anticipating retirement, older adults moving out of their single-family homes can initially move into a coach home or an apartment, secure in knowing that as they develop frailties, they can easily move from one level of acuity to another. Similarities in design elements, colors, and lighting throughout all living units minimize disruption to their lives during such a transition.

Another objective of the village was to design a facility that would meet the tastes and financial needs of the middle-income market. The units integrate a careful choice of building materials, efficient use of square footage, and lighter interior wood tones to achieve this goal.



West Elevation

Senior Life Care Center of the East Bay

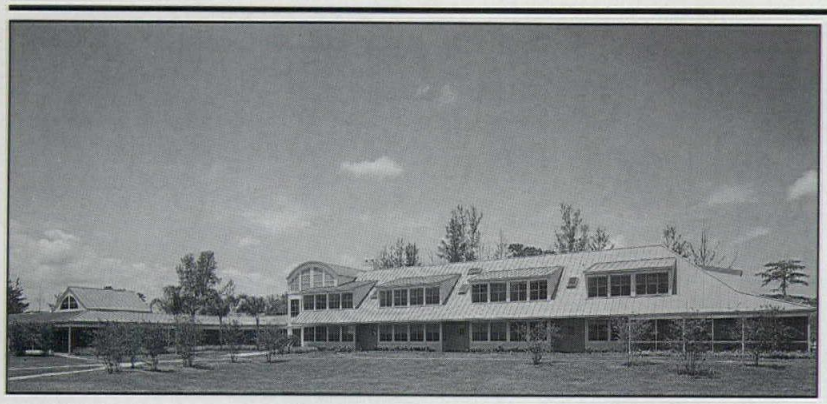


FIRST FLOOR PLAN

Project: Senior Life Care Center of the East Bay, Contra Costa County, California.
Architect: Swatt Architects, San Francisco (Robert Swatt, *principal in charge;* Marcelo Igonda, *project designer;* Eric Kopelson, *project architect;* I. Flynn Rosenthal, *CAD manager;* Thomas Hunter, Carlos Alvarez, *design and graphics;* Katarzyna Kowalska, *graphics*).
Client: The Home for Jewish Parents (Martin Gittleman).
Program: Skilled nursing facility with 250 beds, alzheimer unit, adult day care, chapel, multi-purpose rooms, administration, and central services including a kitchen to serve the nursing facility and also a Meals-on-Wheels program for the surrounding community. Exterior areas to include garden courtyards, with raised planters and a picnic area for residents and their families.
Building Area: 130,000 gross square feet.
Cost: $130/sf.
Completion: 1996 est.
Major Materials: Steel frame, stucco, clay tile and built-up roofing, gypsum board over steel studs, ceramic tile, VCT, plastic laminate, aluminum windows.
CAD-developed? Yes.

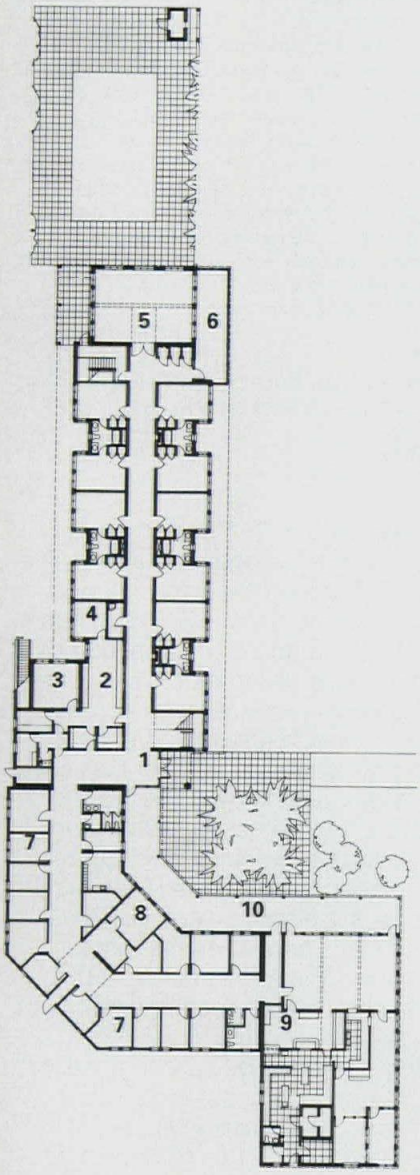
Architect's Statement: The design of the facility is based on a "village" metaphor. The plan is organized around an internal "main street". The 400-foot-long street originates at the chapel and the entrance court and ends in a large multipurpose dining room. The street terraces in half-floor increments to conform to the gently sloping landscape. The narrow feeling of such a long linear element is alleviated at the level changes by curvilinear ramps, alcoves, and views to garden courtyards. A rhythm of overhead natural light is provided by skylights in the village towers. Transportation is assisted by dual half-level elevators and stairs as well as the ramps. Social areas along the street include sitting areas, barber shop, beauty parlor, gift shop, library, and bakery.

Located off the main street are the "neighborhoods" (the nursing units) and "community gardens" (the courtyards). The neighborhoods vary in size from 31 to 42 beds, with the smallest reserved for the residents requiring the greatest degree of nursing care. An Alzheimer unit will occupy the ground floor on the east side of the village. Each neighborhood will have its own social areas such as small-scale dining rooms and multipurpose rooms.

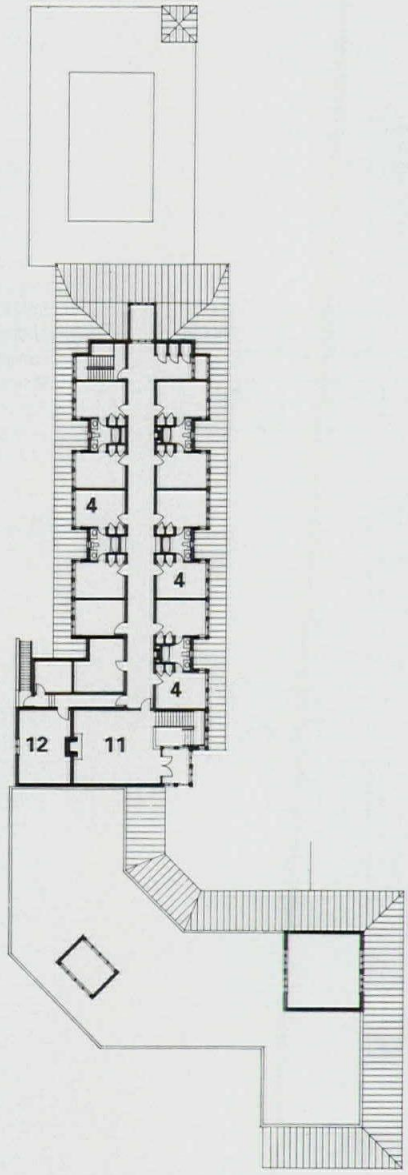


Exterior

The Renfrew Center of Florida



GROUND FLOOR PLAN



SECOND FLOOR PLAN

1 LOBBY
2 NURSING STATION
3 COUNSELORS ROOM
4 PATIENT BEDROOM
5 COMMUNITY ROOM
6 PORCH
7 THERAPY OFFICE
8 CLINICAL DIRECTOR
9 STAFF DINING
10 COVERED ARCADE
11 LIVING ROOM
12 LAUNDRY

N ← 40'/12m

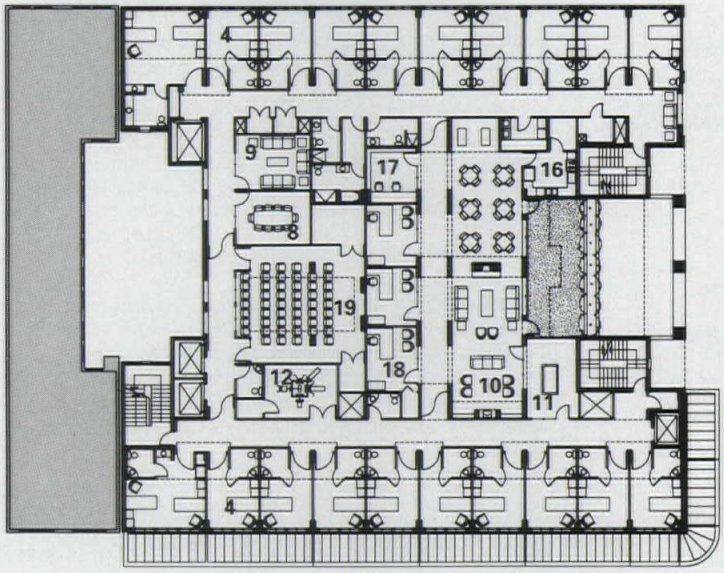
Project: The Renfrew Center of Florida, Coconut Creek, FL.
Architect: Tony Atkin & Associates, Philadelphia, PA (Tony Atkin, *principal;* Gregory Thomas and Simon Tickell, *project architects*).
Client: Premier Medical Systems, Inc.
Building Area: (net/gross, square feet) 29,500/32,500.
Cost: $3.1 million (1991).
Major Materials: Concrete frame, stucco, standing seam metal roof, exposed steel trellises.
Consultants: Domus, Inc. and Roepnack Corporation, general contractors; D.E. Britt Associates, Inc., structural engineer; Norman Bray P.E. Inc., mechanical/electrical engineer.
CAD-developed? No.

Architect's Statement: The Renfrew Center is a residential treatment facility for people with eating disorders. The program called for the conversion of an existing residence and barn into administrative offices and therapy rooms and the construction of a new dormitory and kitchen/dining facility. The owner required that the center have a residential character while still meeting strict institutional standards. The Florida climate allows for an open campus plan with buildings arranged around a pond. New landscaping, using native species, creates a lush tropical garden at the center of the site. The buildings have large roof overhangs and enclosed porches that are used for outdoor meetings and casual gatherings. The complex includes twenty double bedrooms, a ground floor community therapy room, and a large, vaulted second-floor living room. All of the patient rooms have corner views achieved with protruding bays. Access to the new dining hall from the residential building is via the skylighted central corridor of the therapy wing or through a covered exterior arcade.

Central City Lodge

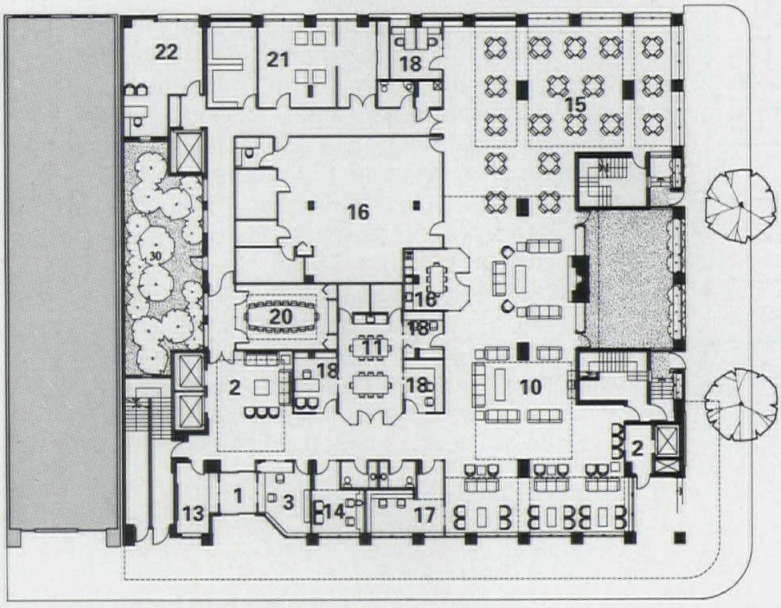
Simon Scott

Model, View from the South East.



SECOND FLOOR PLAN

1 ENTRANCE
2 LOBBY
3 RECEPTION
4 RESIDENT ROOM
5 NURSING
6 TREATMENT
7 OBSERVATION
8 GROUP COUNSELING
9 QUIET ROOM
10 LOUNGE
11 ACTIVITY
12 EXERCISE
13 TUCK SHOP
14 BEAUTY
15 DINING
16 KITCHEN
17 LIBRARY
18 OFFICE
19 MEETING
20 BOARDROOM
21 LAUNDRY
22 HOUSEKEEPING

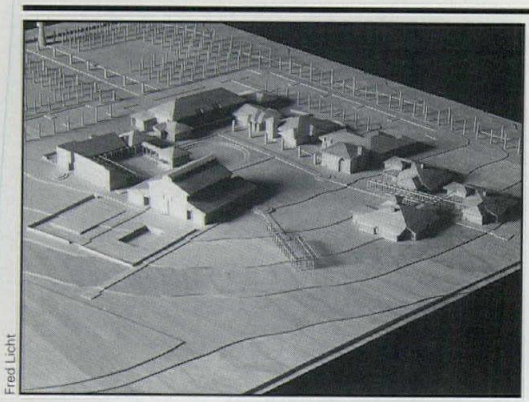


GROUND FLOOR PLAN

N 20'/6m

Project: Central City Lodge, Vancouver, British Columbia.
Architect: Neale Staniszkis Doll Adams Architects, Vancouver, British Columbia (Larry Adams, *partner in charge;* Jerry Doll, Bill Ignatiuk, Kelvin Humenny, Heather Howat, Vince Allen, Sara Rahman, Jonathan Katz, *project team*).
Client: Central City Mission (Alex Reibin, *executive director*).
Program: A new long-term care and treatment facility to house 75 Intermediate Care residents, 25 Special Care residents, and 20 Alcohol Recovery Program (ARP) residents.
Building Area: (net/gross, square feet) 48,750/78,000.
Cost: $120/gsf (1992).
Major Materials: Brick, stone, ceramic tile, EIFS, gypsum board and metal stud partitions, acoustical tile ceilings, aluminum windows, membrane roof.
Consultants: Weiler Smith Bowers, structural; Keen Engineering, mechanical; Mahanti Engineering, electrical; Guzzi Perry & Associates, landscape architect; Metro-Can, contractor.
CAD-developed? Yes.

Architect's Statement: Central City Lodge is a replacement facility for Central City Mission, an inner-city care home that has served the disadvantaged in Vancouver for more than eighty years. A specialized long-term care and treatment facility, the Lodge is intended mainly for those suffering from alcohol- and drug-related illnesses. Since the building is located in the downtown core and is also within a designated heritage area, we wanted it to read as a contemporary urban building while also acknowledging the historical character of the immediate neighborhood. To maximize frontage and light penetration into the building and to preserve light penetration into the adjacent Montgomery Hotel, we structured the plan in an "H" shape, with a southeast-facing courtyard and a light well for the Montgomery. To achieve the programmatic requirements the building is zoned horizontally: amenity and activity spaces on the ground floor; the separately-entered alcohol recovery program on the second; the special care component on the third; intermediate care on levels four, five, and six, and administration and staff on the seventh. Each component has been provided with usable outdoor space. The self-contained, special-care component has an interior and exterior closed-loop circulation system to accommodate wandering psychogeriatric patients.

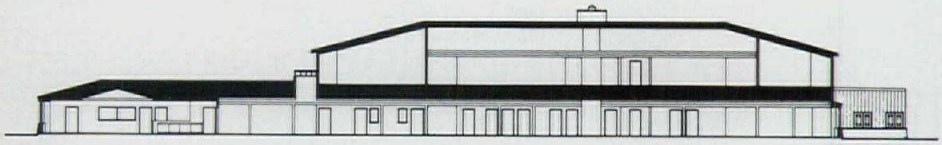


Model

Fred Licht

Casa Pacifica Children's Crisis Care Center

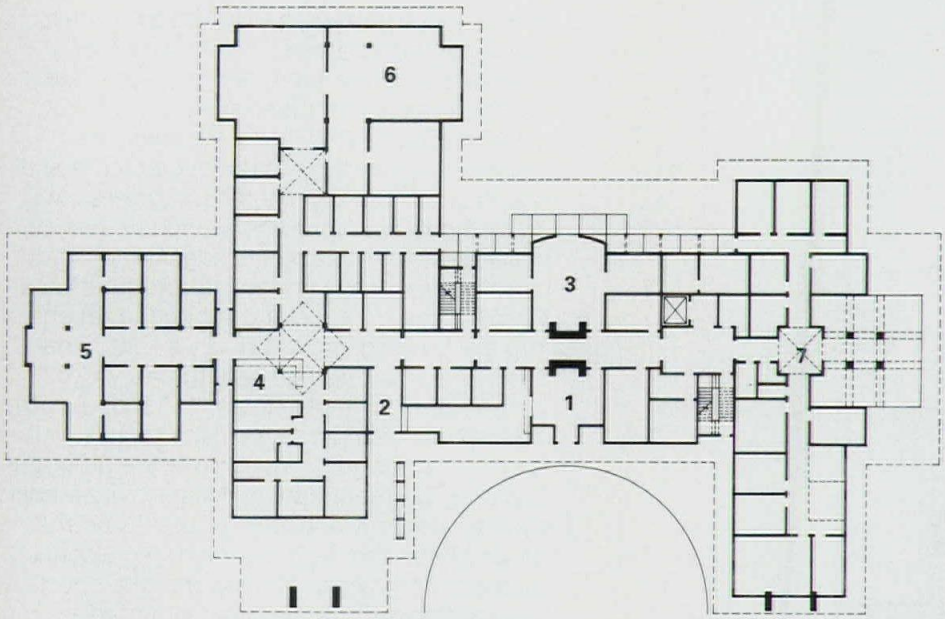
ELEVATION



SECTION A-A

Project: Casa Pacifica Children's Crisis Care Center, Camarillo, CA.
Architect: Bobrow/Thomas & Associates (BTA, Inc.), Los Angeles, CA (Michael Bobrow, *principal for design;* Julia Thomas, *principal for planning;* Chet Wing, *project architect;* Malcolm Brown, *senior designer;* Sina Yerushalmi, Frank Yu, Phil Templeton, and Rey Tura, *project team*).
Client: The Youth Connection.
Program: An emergency shelter for abused and abandoned children, including residential, dining, medical, educational, and recreational facilities.
Building Area: (net/gross, square feet) 38,250/48,000.
Cost: $4.8 million (December 1993).
Major Materials: Stucco, board and batten wood siding, stone veneer, concrete roof tiles.
Consultants: HMH Construction Co., Inc., general contractor; Freet, Yeh & Rosenbach, Inc., structural engineer; Rosenberg & Associates, mechanical engineer; Cohen & Kanwar, Inc., electrical engineer; Design Consortium, landscape architect; Haaland & Associates, civil engineer.
CAD-developed? Yes.

Architect's Statement: The Children's Crisis Care Center will serve as an emergency shelter for abused, abandoned, and neglected children in Ventura County. A typical stay at Casa Pacifica will range from two to 45 days, pending decisions made by the Juvenile Court regarding the status of the child's home environment and the possibility of placement in a foster home. The Center will provide aid to children, from newborns to 17-year-olds. As such, the site plan includes the Children's Cottage for children 4 to 7, the Pre-Teen Cottage for children 8 to 12, and the Adolescent Boys and Girls Cottages for teenagers up to the age of 17. The Nursery for children up to 18 months and the Toddler's Unit for children 18 months to 3 years are located in the Children's Wing of the Casa Pacfica Center, the administrative building on the site. In addition to residential, dining, medical, and educational facilities, 43,000 square feet of the 22.8-acre parcel have been reserved as outdoor activity space, including a swimming pool, a basketball/volleyball court, a baseball field, and play areas.



1 PUBLIC LOBBY
2 CHILDREN'S LOBBY
3 FAMILY VISITING
4 INFIRMARY
5 NURSERY
6 TODDLER UNIT
7 OFFICES

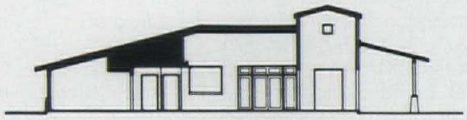
GROUND FLOOR PLAN, CASA PACIFICA CENTER

N ← 40'/12m

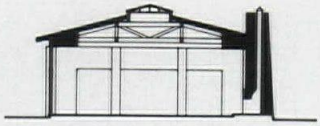
ELEVATION

ELEVATION

ELEVATION

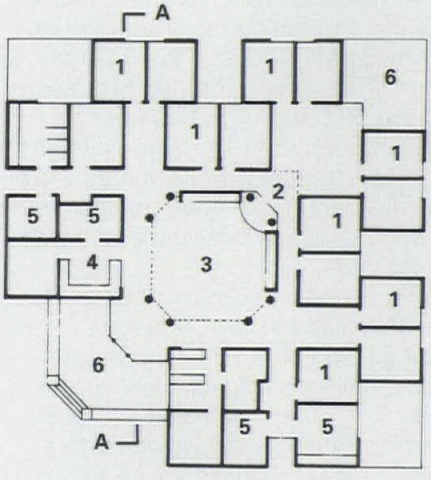


SECTION A-A



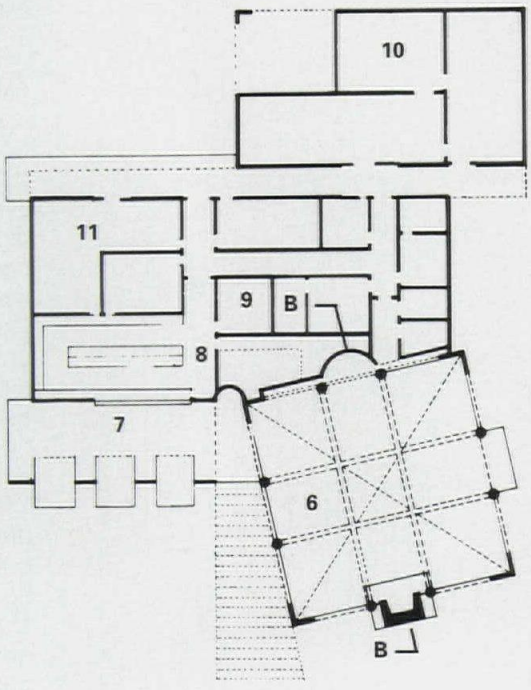
SECTION B-B

SECTION C-C



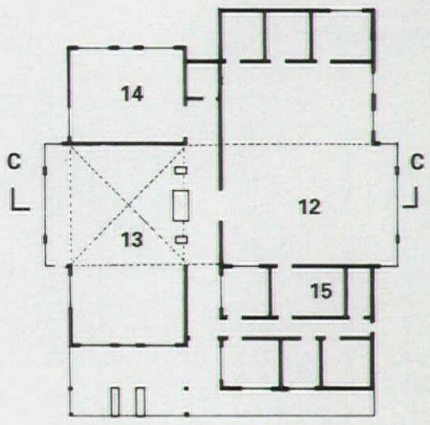
1 BEDROOMS
2 COUNSELOR
3 DAY ROOM
4 KITCHEN
5 OFFICE
6 PORCH

RESIDENTIAL COTTAGE, FLOOR PLAN



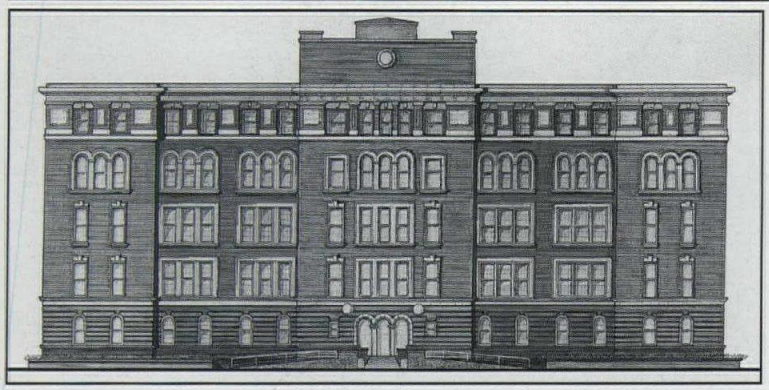
6 DINING ROOM
7 SERVING AREA
8 KITCHEN
9 STORAGE
10 LAUNDRY
11 RECEIVING

DINING HALL, FLOOR PLAN



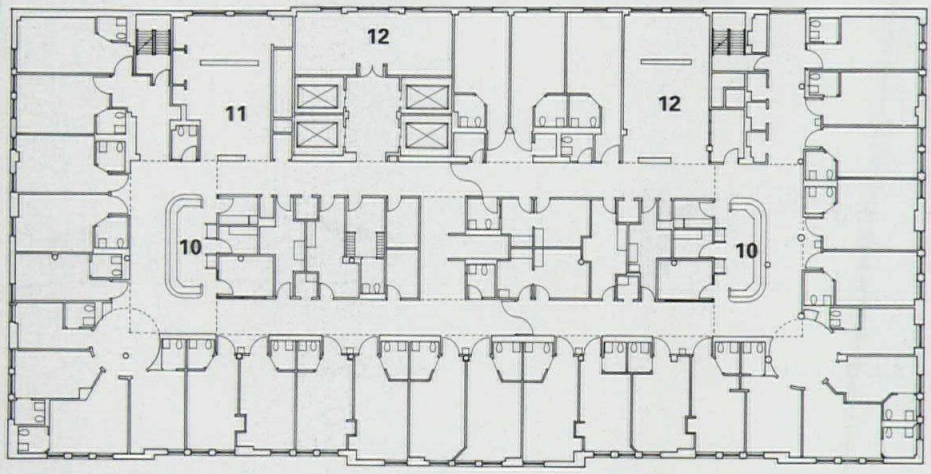
12 SLEEPING AREA
13 DAY ROOM
14 PRESCHOOL
15 OFFICE

CHILDREN'S COTTAGE, FLOOR PLAN



Front Elevation

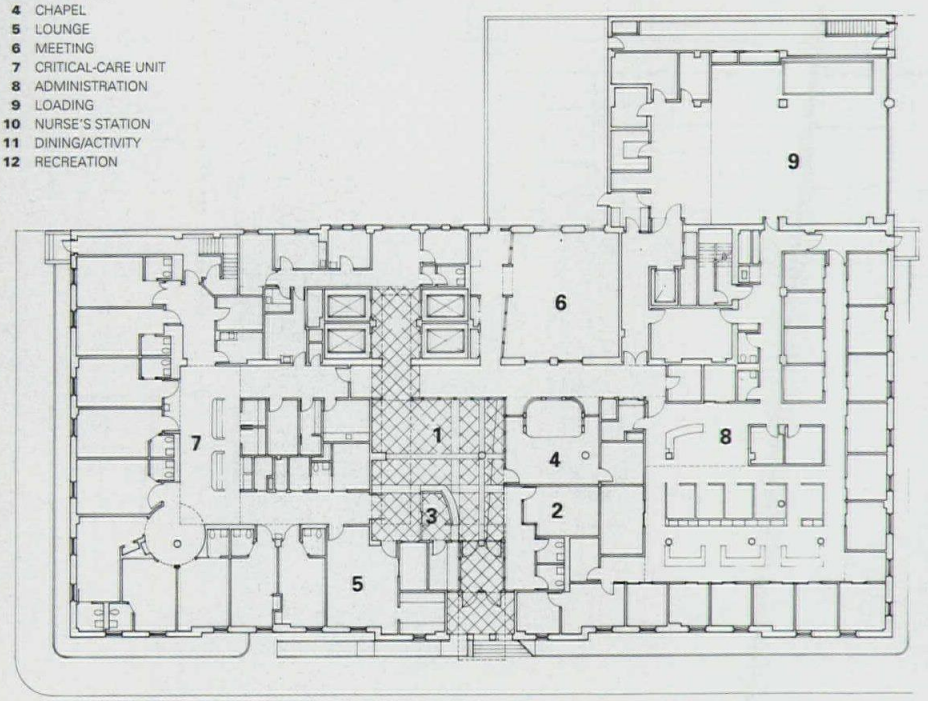
Rivington House



UPPER FLOOR PLAN

Project: Rivington House, New York.
Architect: Perkins & Will and Davis & Brody Associates, New York, (Perkins & Will, Architecture: Donald Blair, *principal in charge;* Bill Nathans, Terry Brennan, *project managers;* Prince Yu, *project architect;* Mary Ann Kalata, *project team;* Interiors: Neil Frankel, *principal in charge;* Tama Duffy, *project manager;* Christine Hluska, *designer.* Davis & Brody, Architecture: Steven Davis, *principal in charge;* John Henle, *project architect;* Brian Sweny, *designer;* Interiors: Maggie Sedlis, Nat Hoyt, *project managers;* John Henle, *designer*).
Client: Village Nursing Home, New York.
Program: Renovation and conversion of a grammar school (circa 1898) into a 241-bed nursing facility, with food service, dining, administration, and housekeeping facilities, and a radiology suite and clinical laboratory.
Building area: (net/gross, square feet) 90,000/130,000.
Cost:$200/sf
Major materials: Bonded-brick walls, tile-arch floors, cast iron columns, granite footings, steel-frame addition.
Consultants: Ernest Keller, planning; Alfred Selnick, structural; Edward A. Sears Associates, mechanical, electrical and plumbing; Romano Gatland, food service; D.T.M. Inc., elevator consultant; E.P.I., medical equipment planners; Integral Construction Company, construction management.
CAD-developed? No.

1 LOBBY
2 GIFTS
3 RECEPTION
4 CHAPEL
5 LOUNGE
6 MEETING
7 CRITICAL-CARE UNIT
8 ADMINISTRATION
9 LOADING
10 NURSE'S STATION
11 DINING/ACTIVITY
12 RECREATION



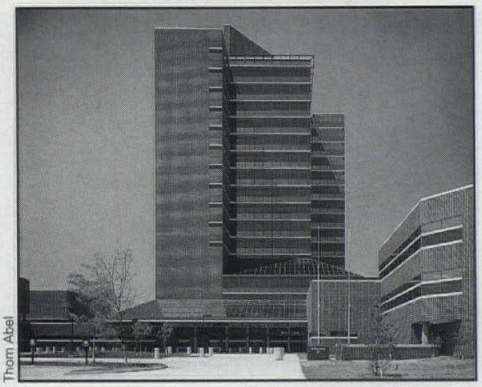
FIRST FLOOR PLAN

N 40'/15m

Architect's statement: The Rivington House is a 241-bed nursing facility for AIDS patients housed in a former New York City school building. The basement is used for building services, kitchen and dining facilities, and a radiology suite and clinical lab. The first floor houses administrative areas and a 17-bed critical care unit. The second through fifth floors will each have 56 beds, with two nursing units per floor. Each of the nursing units has a dining/recreation facility and a shared recreation area. The penthouse floor provides multipurpose space and physical and occupational therapy facilities.

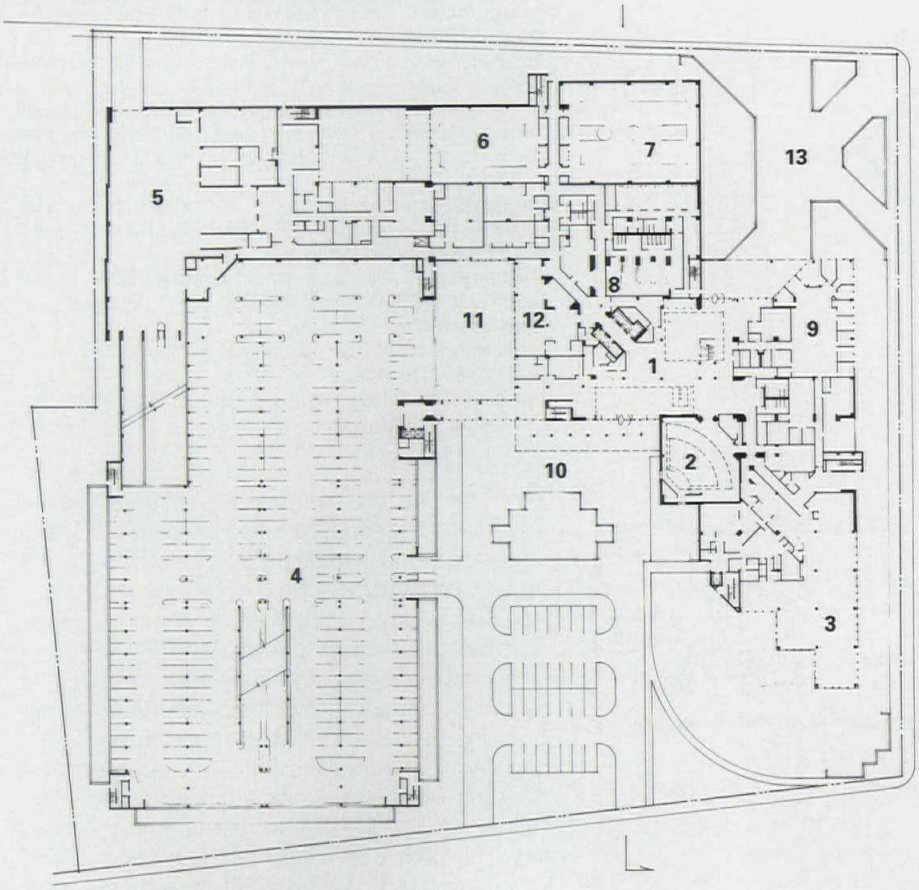
The existing five-story grammar school has brick exterior walls with large windows, terra cotta moldings, and ornamental ironwork. A new addition infills the original building's U-shaped plan. The project achieves the dual goals of public service and building restoration, providing a critical public health facility while restoring an important element in the fabric of the community.

W.O. Walker Industrial Rehabilitation Center

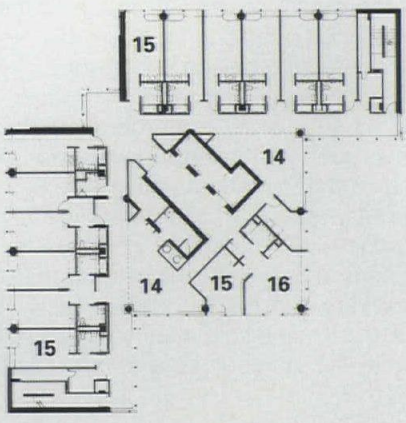


Thom Abel

View of Tower



FIRST FLOOR PLAN N → 80'/24m



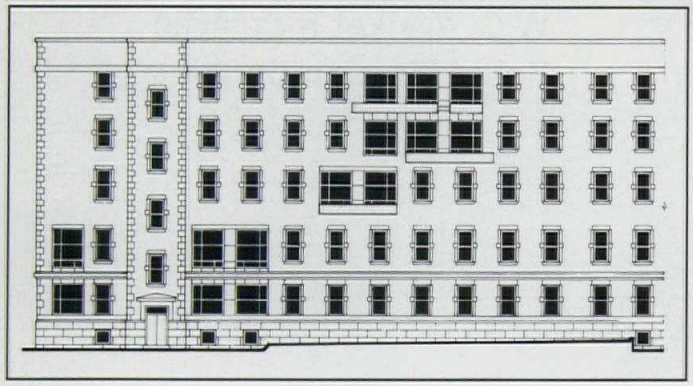
TYPICAL FLOOR PLAN N → 40'/12m

1 LOBBY
2 AUDITORIUM
3 DINING
4 PARKING
5 SERVICE
6 POOL
7 BASKETBALL
8 LOCKERS
9 ADMINISTRATION
10 PATIENT DROP-OFF
11 COURTYARD
12 RECREATION
13 PLAZA
14 LOUNGE
15 BEDROOM
16 LIVING ROOM

Project: W.O. Walker Industrial Rehabilitation Center, Cleveland, OH.
Architect: Collins, Rimer & Gordon, Cleveland, OH (William H. Collins, *principal in charge;* Randall J. Gordon, *principal in charge of design;* Henry E. Kawalek, *principal in charge of field administration*).
Client: State of Ohio Industrial Commission.
Program: Provide medical and vocational rehabilitation facilities and housing on a 9-acre site in the University Circle area of Cleveland.
Building area: (net/gross, square feet) 414,000/630,000, (garage) 216,000 gsf.
Cost: $57,243,614 (1988).
Major materials: Poured-in-place concrete structural system, 8X8 face brick, tubular steel truss curtain wall, steel frame for gymnasium and industrial program areas.
Consultants: Barber-Hoffman, structural; M-E Building Consultants, mechanical/electrical; William Behnke & Associates, landscape; Snavely-Burkes, construction manager.
CAD-developed? Yes.

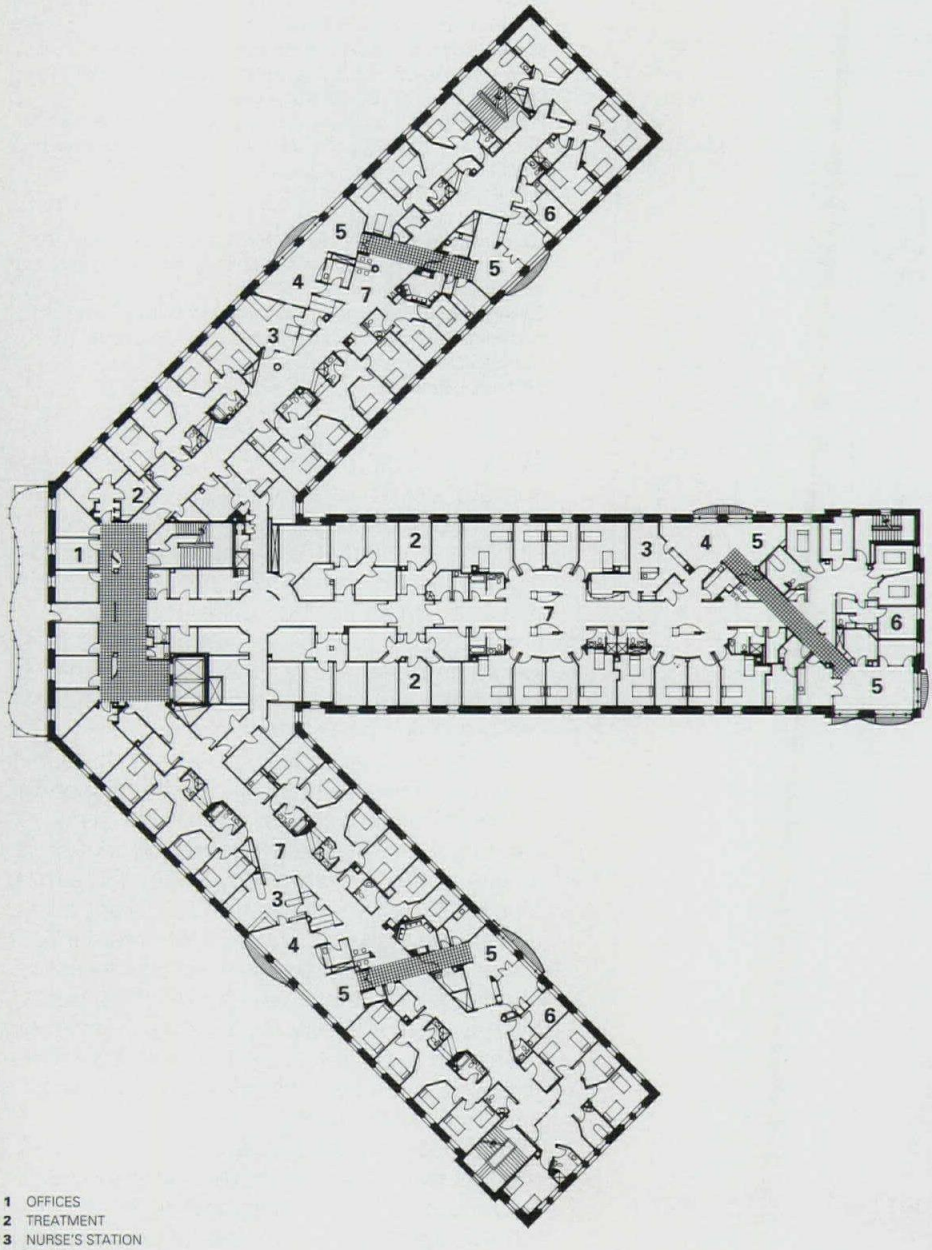
Architect's statement: This facility provides a comprehensive array of medical and vocational rehabilitation services. Major design considerations included creating an unintimidating and easy-to-use facility, providing security within an urban setting, minimizing operational costs, and making interior spaces that would encourage and enhance comprehensive treatment. The building's base defines the beginning of the city block grid and engenders visual accessibility from the outside to activities within. Brick was chosen for its durability and local character, but also because it aesthetically echoes the industrial quality of the Cleveland cityscape. In a similar fashion it implies the Center's ancillary relationship to industry. The 15-story residential tower provides a prominent vertical terminus to one of the main avenues extending out from Cleveland's downtown area. Residential rooms on each of the top nine floors are clustered around a central counselor's quarters and two lounge areas.

The Center's wholistic approach to treatment is evident in its six treatment modules. Each module is self-contained, allowing a interdisciplinary team to handle as many as 75 clients per day. Serving the treatment modules are a stainless-steel pool and 1/4 mile indoor running track. Adjoining the building is a three-story, 650-car garage.



Partial North Elevation

Pavillon Solange-Cloutier



FIFTH FLOOR AFTER RENOVATION

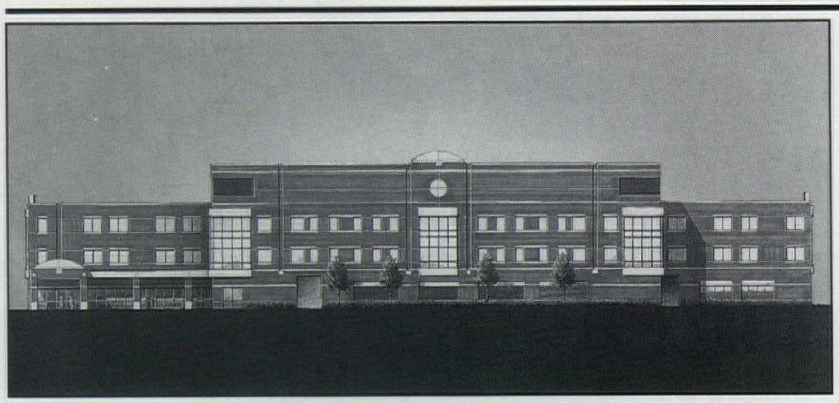
N 40'/12m

Project: Pavillon Solange-Cloutier, Hopital Louis-H. Lafontaine, Montreal, Quebec.
Architect: Les Architectes Tetreault, Parent, Languedoc et Associes, Montreal, Canada (Paul-Andre Tetreault, *partner in charge,* Serge Perras, *administrative assistant,* Raynald Saint-Hilaire, Sylvie Girard, Marie-Claude Lefebvre, *design team,* Andre Yelle, *design consultant*).
Client: Hopital Louis-H. Lafontaine and Corporation d'Hebergement du Quebec.
Program: A complete reshaping of a five-story building comprising ten psychiatric care units, with 286 long- and short-term beds and multidisciplinary medical services.
Building Area: (net/gross, square feet) 93,000/143,200.
Cost: $11,400,000 CAN ($9,150,000 US).
Construction date: 1991 to 1994.
Major materials: natural stone, anodized aluminum panels and expanded aluminum shells.
Consultants: Bouthillette, Parizeau et Associes, mechanical & electrical; Rousseau, Sauve, Warren, structural.

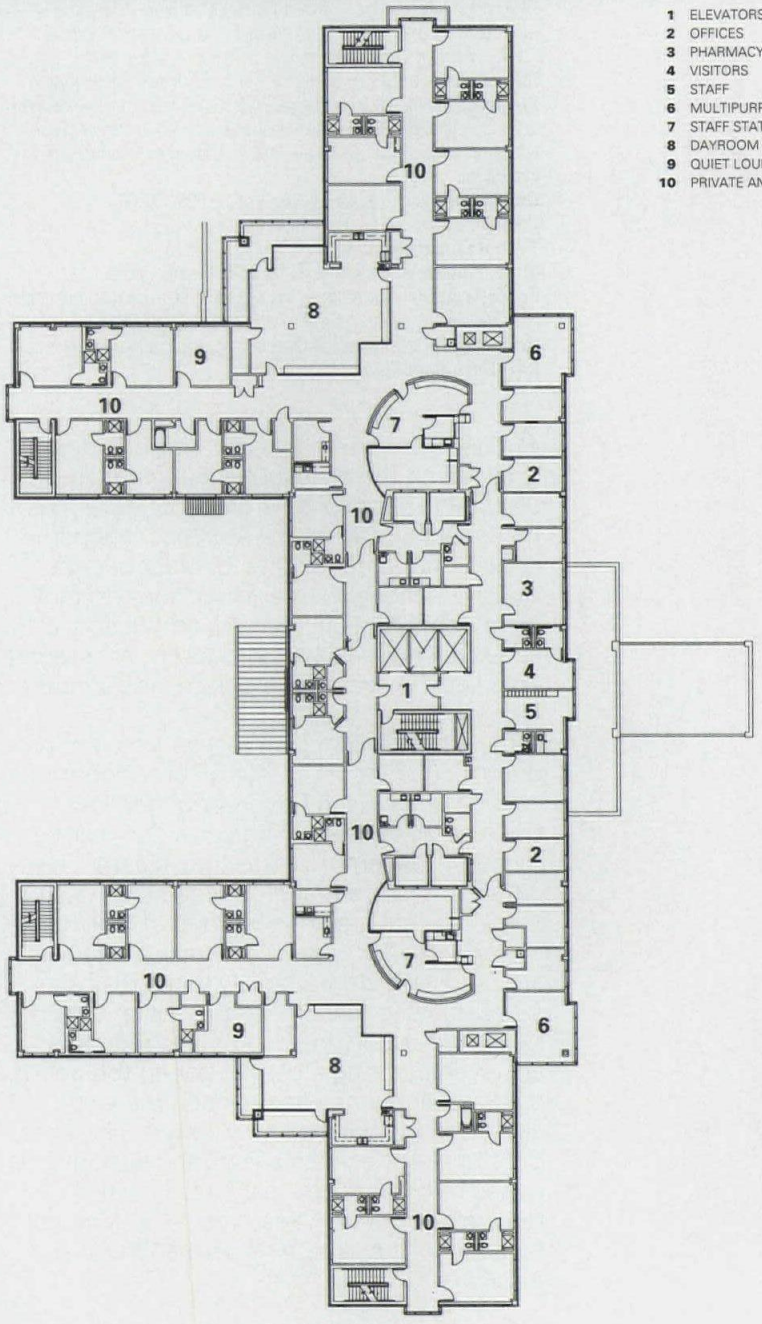
Architect's Statement: Built in 1934, this psychiatric hospital needed an in-depth renovation to meet modern-day objectives of "deinstitutionalization". Four types of organizations have been developed according to the different psychiatric pathologies. Two arrangements were designed for people needing medium surveillance: curved configurations for more dependent patients and angular configurations for more autonomous patients. Also, the plans are modulated with respect to the location of the unit in the building. The best was made of the beautiful landscape surrounding the institution by creating view axes from the community spaces. Large openings through the facades break the monotony of the building and bring light to the heart of the nursing units. Although space for treatment, living quarters, and complementary activities border each other, they promote different living scenarios.

The bedrooms are distributed around small living rooms, creating an intermediary area for socialization like that found in a private residence. Geometry and room organization thus promote intimacy of the patients while insuring adequate surveillance. At the intersection of the three wings, there are common facilities for groups or multidisciplinary teams and spaces capable of being adjusted to individual therapies.

ARH Center for Mental Health



Front Elevation



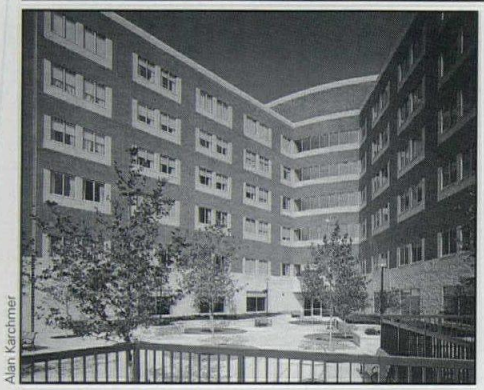
SECOND FLOOR PLAN

Project: Hazard Appalachian Regional Hospital, ARH Center for Mental Health, Hazard, Kentucky.
Architect: Sherman-Carter-Barnhart, Lexington, Kentucky (Charles E. Barnhart, III, *partner in charge;* Timothy A. Murphy, *design architect;* Tim Sexton, Steve Tyner-Wilson, *project managers;* Sam Basin, *CADD Coordinator*).
Client: Appalachian Regional Healthcare, Lexington, Kentucky.
Program: Design a 100-bed, freestanding, three-story psychiatric addition to an existing hospital.
Building area: 88,200 gross square feet.
Cost: $12,600,000.
Major materials: Steel frame structure with post-tensioned first floor, and steel deck and concrete second and third floors; brick masonry on metal studs; caisson foundation system; built-up roofing.
Consultants: Graham-Meus, consulting architects; Parrot, Ely & Hurt, civil; Poage Engineers, structural; Staggs & Fisher, mechanical/electrical; Stoley-Cheeks, geotechnical.
CADD-Developed? Yes.

Architect's Statement: The ARH Center for Mental Health is a new psychiatric addition connected, via an enclosed corridor to the back-up medical, food service, and housekeeping support of an existing hospital. The psychiatric addition has self-contained psychiatric treatment services, therapy, admissions, records, administration, and recreational areas.

The building is organized around the first-floor patient commons, which links the occupational therapy, recreational therapy, gymnasium, cafeteria, and private outdoor patient courtyard together. Also at the first floor are the emergency entrance, administrative offices, and visitors lobby for efficient admission and discharge of patients.

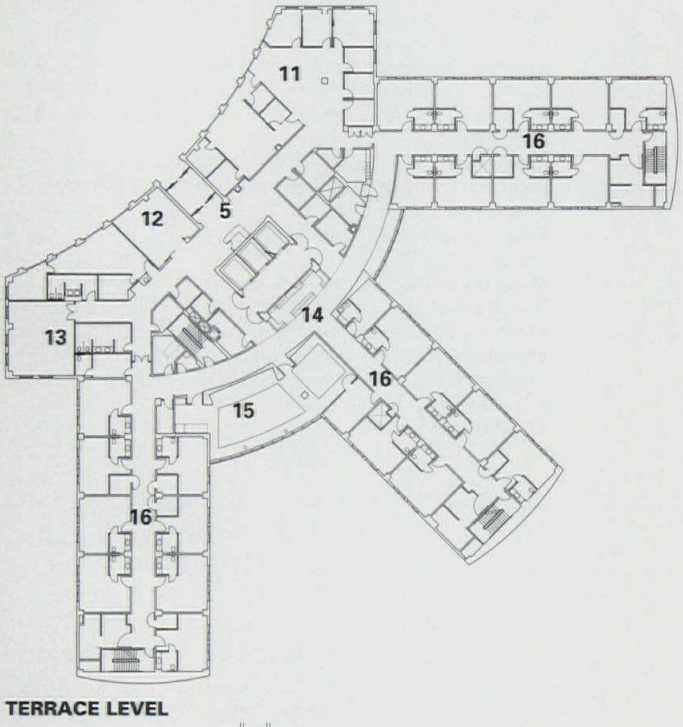
For privacy and security, the patient units are located on the second and third floors, which are linked to the first floor by an main stairway and multiple elevator core. Each patient unit is organized to incorporate design concepts that are familiar and understandable to patients, reducing disruption and confusion and creating a sense of safety and comfort. Ancillary counseling rooms and staff offices are located adjacent to the patient units on each floor. Each patient floor is divided into two areas, with each area controlled by a central station from which staff can monitor each patient room wing as well as the patient day room.



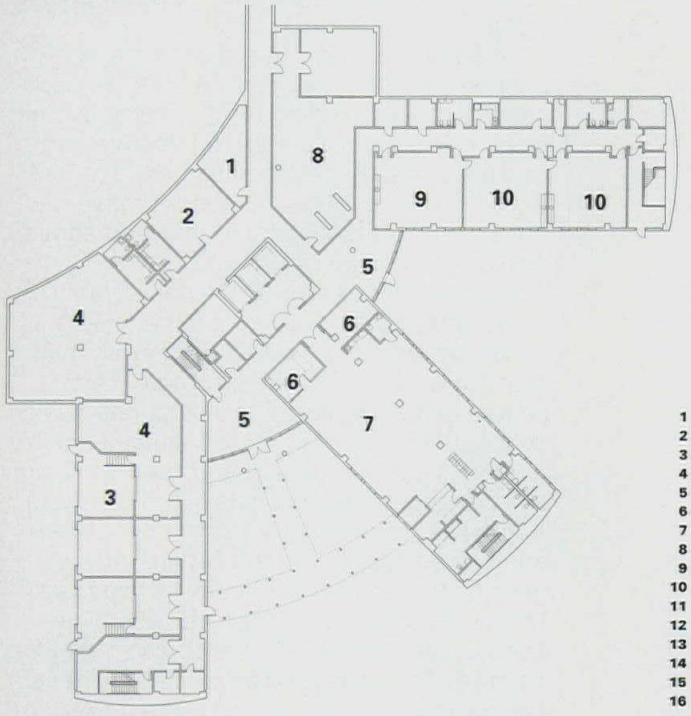
Alan Karchmer

View From of Terrace

Johns Hopkins Geriatric Facility



TERRACE LEVEL



GARDEN LEVEL

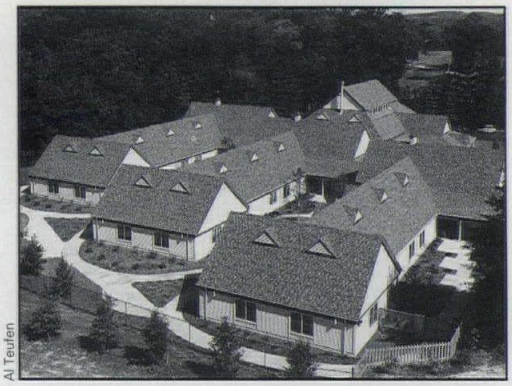
1 LAB
2 DIALYSIS
3 DOCKS
4 STORAGE
5 LOBBY
6 TREATMENT
7 PHYSICAL THERAPY
8 MECHANICAL
9 DAYCARE
10 CLASSROOM
11 ADMINISTRATION
12 GIFT SHOP
13 CONFERENCE
14 NURSE'S STATION
15 DINING/ACTIVITY
16 PRIVATE AND SEMI-PRIVATE ROOMS

N ↑ 40'/12m

Project: Johns Hopkins Geriatric Facility, Baltimore, Maryland.
Architect: Ellerbe Becket, Inc./Washington, D.C. (John Michael Currie, *principal in charge*).
Client: Francis Scott Key Medical Center, Baltimore, Maryland.
Program: Design a new freestanding 250-bed geriatric care center to provide the full range of geriatric services as well as research and teaching facilities for the Johns Hopkins University Health System Institution.
Building Area:(net/gross, square feet) 80,000/132,000.
Cost: $113.63/gross sq ft.
Year of Construction: 1991.
Major materials: Brick, ground-face block, stone, glass.
Consultants: Hellmuth, Obata and Kassabaum, associate architects; Post Buckley Schuh & Jernigan, civil; Schnabel Engineering, geotechnical; Atlantic Code Consultants, code; Innovage, geriatric consultant.
CAD-Developed?Yes.

Architect's Statement: The Center's design is based on the philosophy that carefully planned residential environments have the potential to improve life, increase independence, and foster dignity for older people. Major functional elements include resident units; rehabilitation, therapy, ambulatory care and academic research programs; an integrated adult/child daycare program; and support functions.

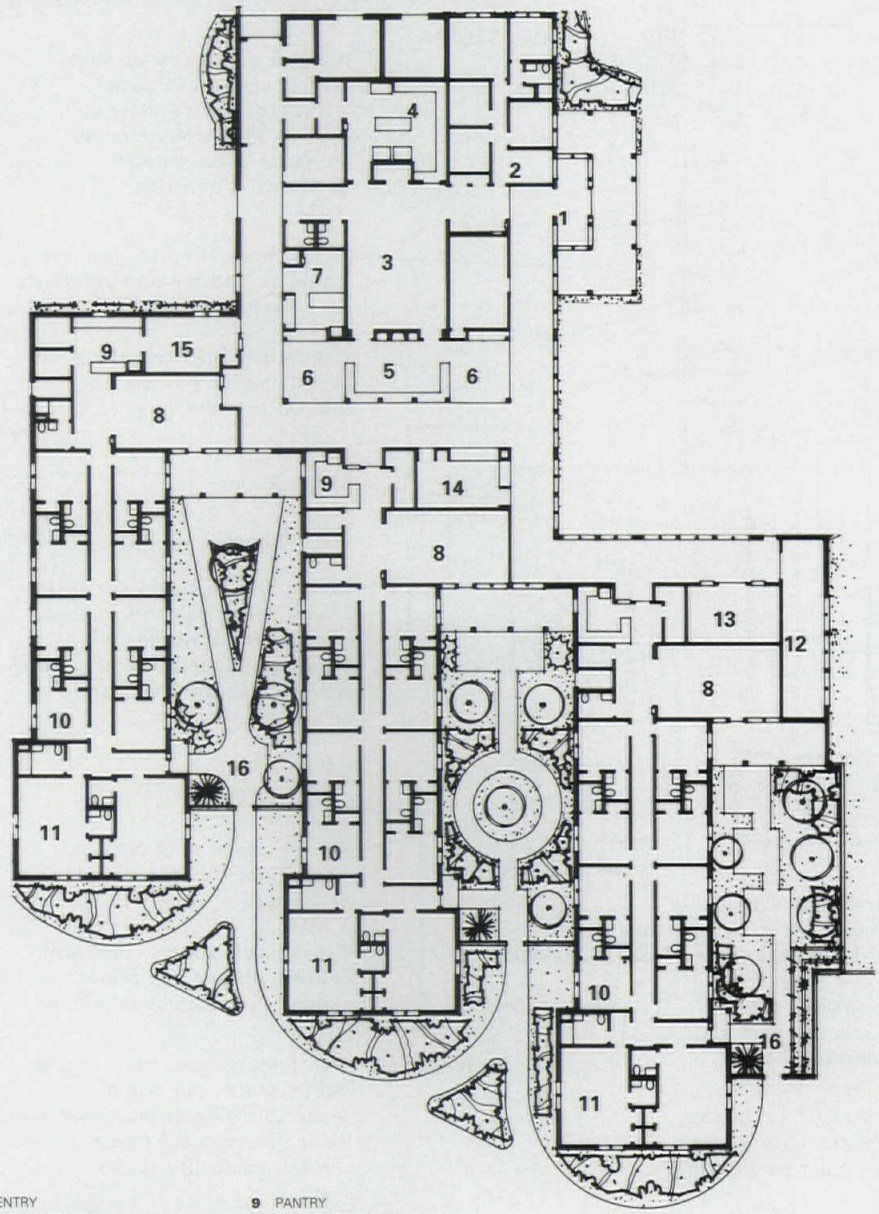
The tripartite floor plan results from the program's concept of "clusters" of resident nursing units. Each floor is arranged into three small clusters, with basic daily care functions decentralized to the "cluster" level rather than at centralized nurse stations. The three clusters are connected to a "main street" corridor and the central nursing station. Clusters are purposely kept small and self-contained to increase the sense of home. Personal territory in semi-private rooms is achieved by using a bi-axial (toe-to-toe) room configuration, providing residents equal access to the bathroom, windows, and door. Careful attention was paid to the specific needs of older people particularly with regards to "control" features — doorknobs, faucets, toilets, light fixtures, handrails, and furniture.



Al Teufen

Aerial View

Woodside Place at Presbyterian Medical Center



1 ENTRY
2 ADMINISTRATION
3 GREAT ROOM
4 MAIN KITCHEN
5 LIBRARY
6 SITTING AREA
7 COUNTRY KITCHEN
8 LIVING/DINING ROOM
9 PANTRY
10 SINGLE BEDROOM
11 DOUBLE BEDROOM
12 QUIET ROOM
13 MUSIC ROOM
14 ARTS AND CRAFTS ROOM
15 ENTERTAINMENT ROOM
16 SECURE COURTYARD

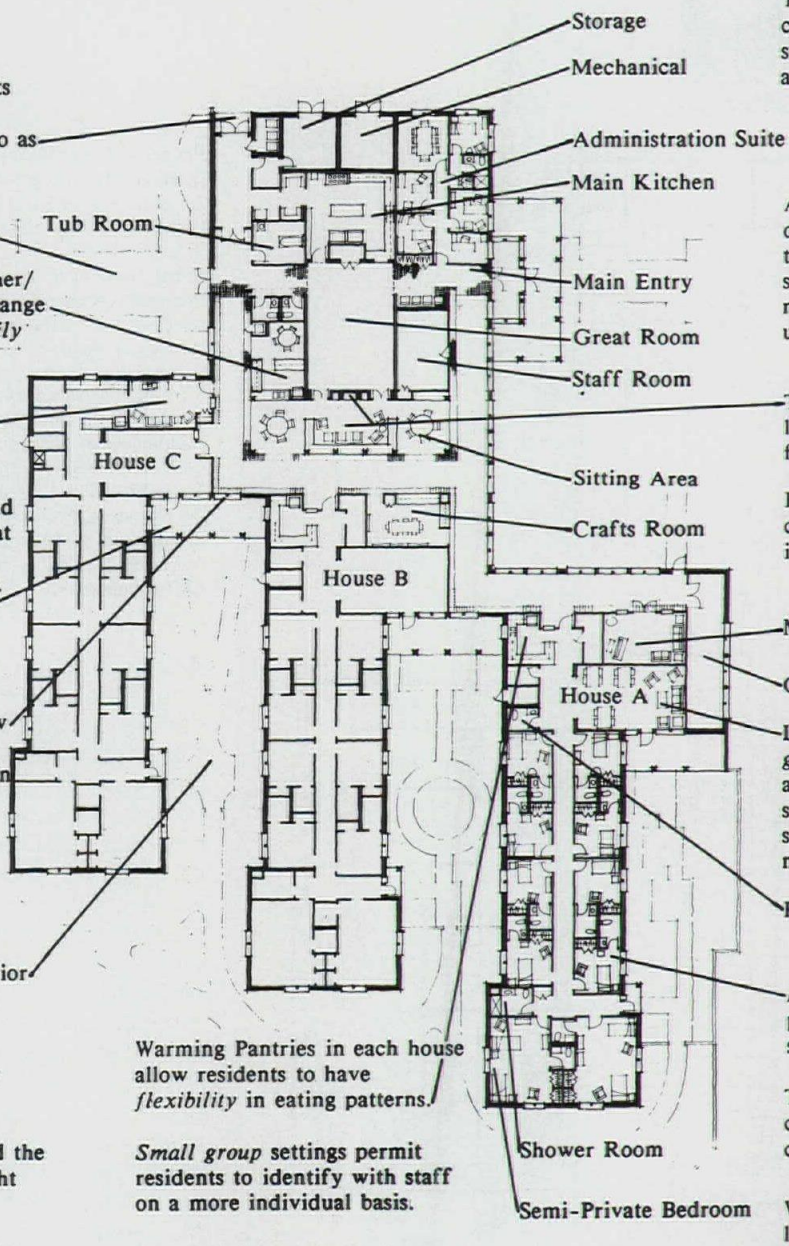
GROUND FLOOR PLAN

N 40'/12m

Project: Woodside Place at Presbyterian Medical Center, Oakmont, PA.
Architect: Perkins Eastman & Partners, New York, (J. David Hoglund, *principal in charge;* Susan DiMotta, *director of interiors;* Joseph DesRosier, Barbara Geddis, Kurt A. Jorgensen, Bradford Perkins, Polly D. Stone, *staff*).
Client: Presbyterian Association on Aging of Oakmont.
Program: A housing development for 36 people with Alzheimer's disease, planned as a residential alternative to a conventional skilled nursing care model. Particular emphasis was placed on the need to design an experimental program for design/behavioral research that will explore the full range of housing and environmental issues within a traditional residential community setting.
Building Area: (gross, square feet) 23,000.
Cost: $2,100,000/$91.30 per sf.
Major Materials: Vinyl siding, wood trim, asphalt shingle roof, cladwood windows, wood frame.
Consultants: R.F. Mitall & Associates, civil; L.D. Astorino & Associates, Ltd., local architect and engineer.
CAD-developed? No.

Architect's Statement: The first facility of its kind, Woodside Place offers a special care setting dedicated to the special needs of Alzheimers patients. Providing a residential setting for 36 people, Woodside Place incorporates the most advanced programs and environmental design features aimed at stabilizing dementia and improving the quality of life for its residents. Our design goal was to create a comfortable, familiar environment where activity, mobility, and sensory stimulation were encouraged. Traditional institutional models that enforced highly structured social interaction, rigid daily living patterns, and intrusive security measures were rejected because they have not proved to be effective in slowing the onset of dementia. In many cases, these models may even hasten the progress of the disease in an individual who has been abruptly removed from his or her familiar surroundings. We used sensory cues to identify traditional rooms and jog residents' memory of significant events and activities to counter the loss of memory and orientation. Organized as three houses, each has familiar landmarks providing a clear identity. Other amenities include a music room, a country kitchen, an arts studio, a library, courtyards, and secure outdoor areas providing informal settings for daily activities .

Design Issues



A discrete staff entrance limits resident agitation at shift changes, sometimes referred to as *sundowning* behavior.

Group Outdoor Activities

The country kitchen and washer/dryer permit meaningful exchange and encourage *caregiver/family participation.*

Entertainment (TV) Room

"High risk" areas such as the country kitchen are visible and accessible to staff areas so that residents may maintain *independence* yet remain *safe.*

Covered Porch

Windows into courtyards allow residents to be unobtrusively observed by staff and maintain *safe* experiences.

Secure Courtyards allow exterior *wandering.*

Views to the outside not only enhance *orientation* but provide experiences to the changing cycle of the day and the corresponding *rhythms* of night and day.

The Music Room, Country Kitchen and Crafts Room provide visual, auditory and olfactory landmarking for *orientation.*

Warming Pantries in each house allow residents to have *flexibility* in eating patterns.

Small group settings permit residents to identify with staff on a more individual basis.

Artwork themes (trees, houses, stars) can differentiate spaces and reinforce color cueing for *orientation.*

The external *residential* image conveys an important message to staff and visitors about the approach to care.

A range of room sizes with distinct purposes (music, television, crafts) allow the staff to alter group sizes to minimize *agitation* and unwanted stimulation.

The Library fireplace provides a landmark and point of reference for *wayfinding.*

Events and activities along the corridors give purpose and interest to *wandering.*

Living/Dining rooms for *small groups* allow residents to enjoy a less stressful *residential* style experience while permitting staff to monitor health and nutritional intake.

Private rooms with personal possessions enhance a person's self-image.

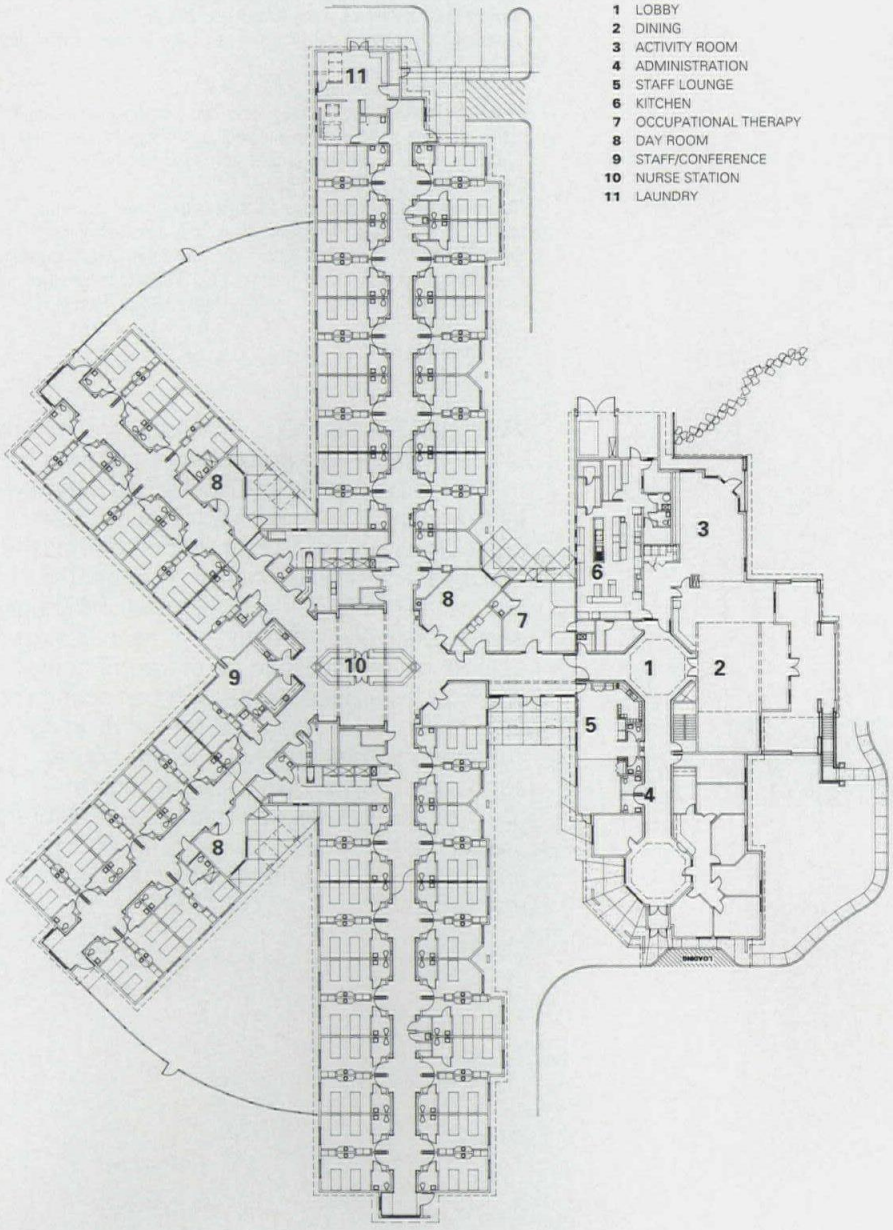
Trunks and baskets filled with clothes, pillows and fabrics channel *rummaging* activities.

Wall light sconces and hanging light fixtures can become removable objects that make rooms distinctive and enhance a *residential* quality to the space.

Patrick Barta

View of Entrance

Gig Harbor Extended Care Center



FIRST FLOOR PLAN

N ↑ 40'/12m

Project: Gig Harbor Extended Care Center, Gig Harbor, WA.
Architect: Merritt + Pardini, Tacoma, WA (LeRoy J. Pardini, *principal in charge;* Bret A. Drager, *project architect/designer*).
Client: A & R Partnership.
Program: Provide a 120-bed long-term care facility for a variety of patients, from Medicare to private patients. Included are a childcare facility for staff and an Alzheimer's wing with its own nurse's station.
Building Area: (net/gross, square feet) 38,000/46,000.
Cost: $67/gsf (1990).
Major Materials: wood frame, cedar siding, stone, asphalt roof.
Consultants: AHBL, structural; HCE, civil; Lynn William Horn, landscape; Susan Whaley, interior design; W.G. Clark Construction, general contractor; Tacoma Plumbing & Heating, plumbing design/build; Unity Electric, electrical design/build; Merrit Mechanical, HVAC design/build.
CAD-Developed? Yes.

Architect's Statement: This free-standing, 120-bed extended care center is focused on an enclosed courtyard that grants patients privacy and freedom without compromising their security. Each of two 60-bed patient wings is served by a central nurse's station with visual access to all corridors. The facility features a 20-bed Alzheimer's area with its own nurse's station, day room, bathing facilities, and secure courtyard.

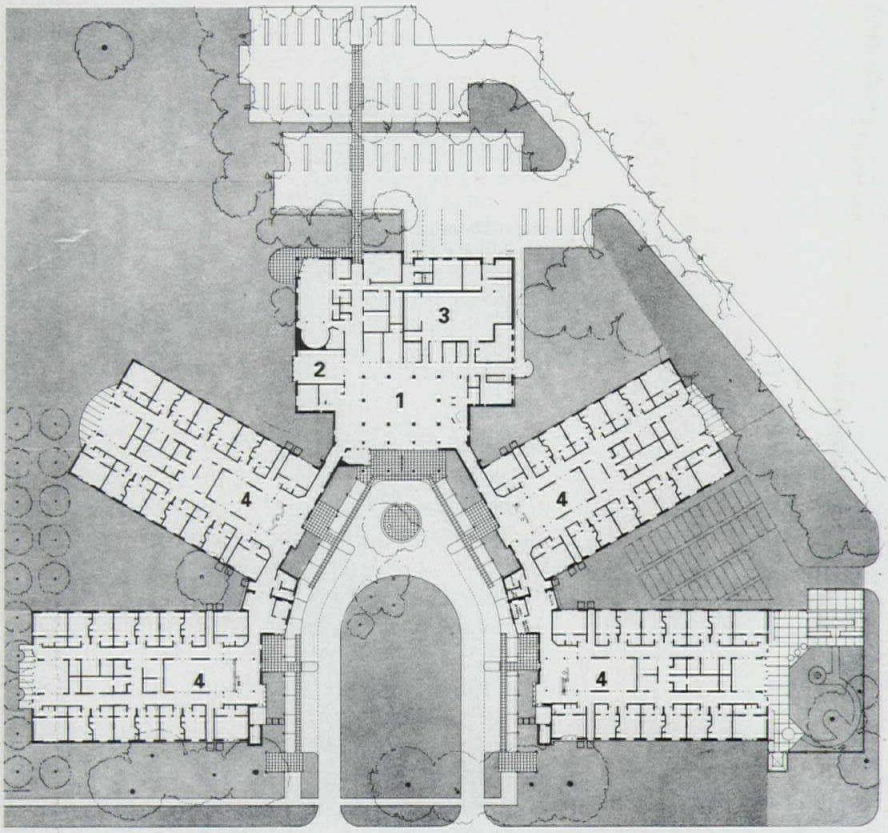
Inside, the scale and detailing bespeak a residential setting, rather than an institutional one. Elevated ceilings render the corridors open and airy, while indirect lighting minimizes the patient disorientation that often accompanies failing eyesight.

The center is located in a medically-oriented development area, with a drug and alcohol treatment clinic, a pharmacy, and anticipated assisted living facilities nearby. The facility's exterior design is respectful of Gig Harbor's rural character. The small scale of the buildings, as well as their natural finishes and materials, conform to the area's development guidelines.

The care center houses a variety of residents ranging from Medicare recipients to private patients. Fifty assisted living units provide for an intermediate level of care to patients preferring to maintain a high measure of personal independence. Amenities include child and adult daycare and physical therapy facilities.

Elevation of Town Hall Flanked by Resident Houses

Gilmore Lodge Home for the Aged



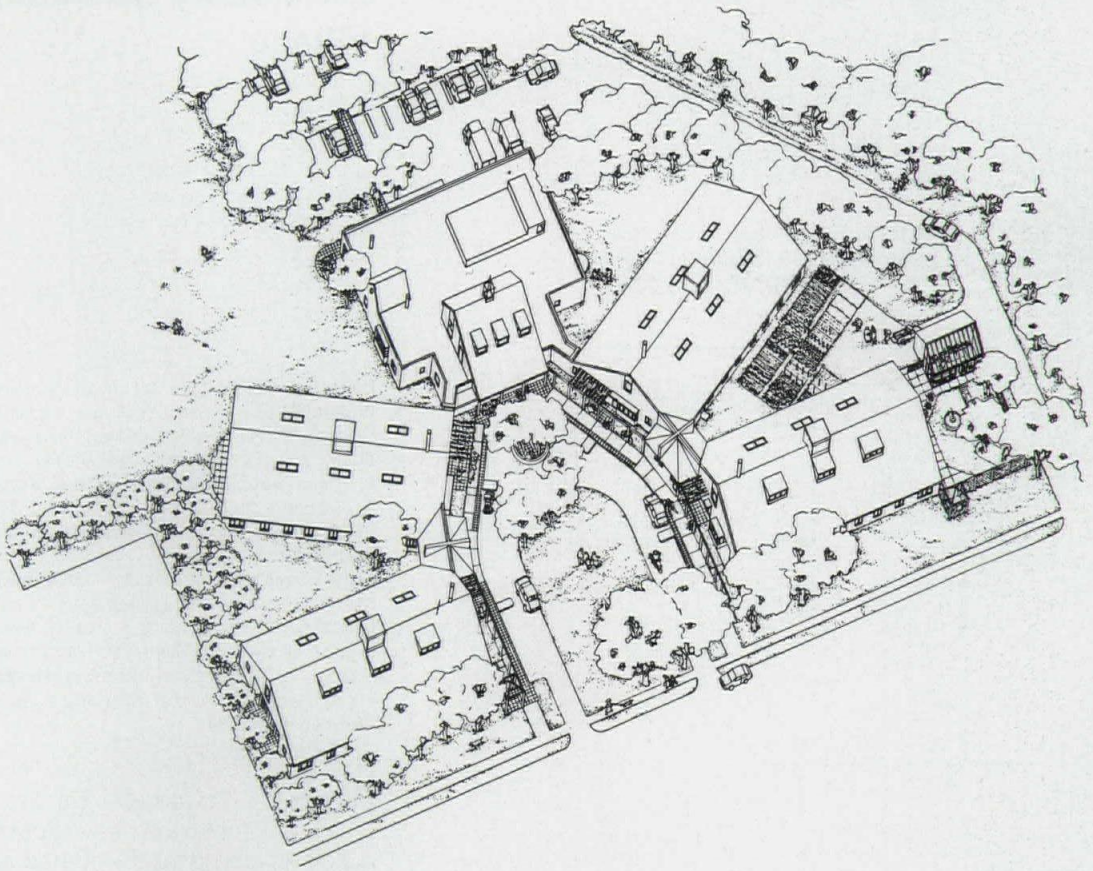
Project: Gilmore Lodge Home for the Aged, Fort Erie, Ontario.
Architects: Chapman Murray Associates, Niagara Falls, Canada/Montgomery and Sisam, Toronto, Canada, joint venture architects.
Client: Regional Municipality of Niagara.
Program: A new home for 80 aged residents configured as four 20-resident houses with a central building surrounding an entry court.
Building Area: (net/gross, square feet) 26,950/44,456.
Cost: $4,350,000, or $98/sf (1987).
Major Materials: Wood frame (with structural steel for central building), brick veneer, aluminum siding, and asphalt shingles.
Consultants: Omen Lee and Associates, structural; Swan Wooster Engineering, mechanical and electrical; A.J. Vermeulen, surveyor, Myra Schiff environmental psychology; Nelson Hofer, food facility design.
CAD-developed? No.

Architect's Statement: The domestic nature of the project provides a pleasant alternative to counterparts that emphasize the institutuional and clinical aspects of extended care. The home comprises four 20-person houses and a central services building connected around an entry court off the road. The houses are relatively self-sufficient, each having its own trellised garden on the entry court. The houses are identical; each can accommodate any level of care. The central building contains the main entrance to the home, administrative, and staff spaces, and a daycare center. Resident facilities — a library, chapel, barber, and shop — surround an interior "town square" that doubles as a performance space.

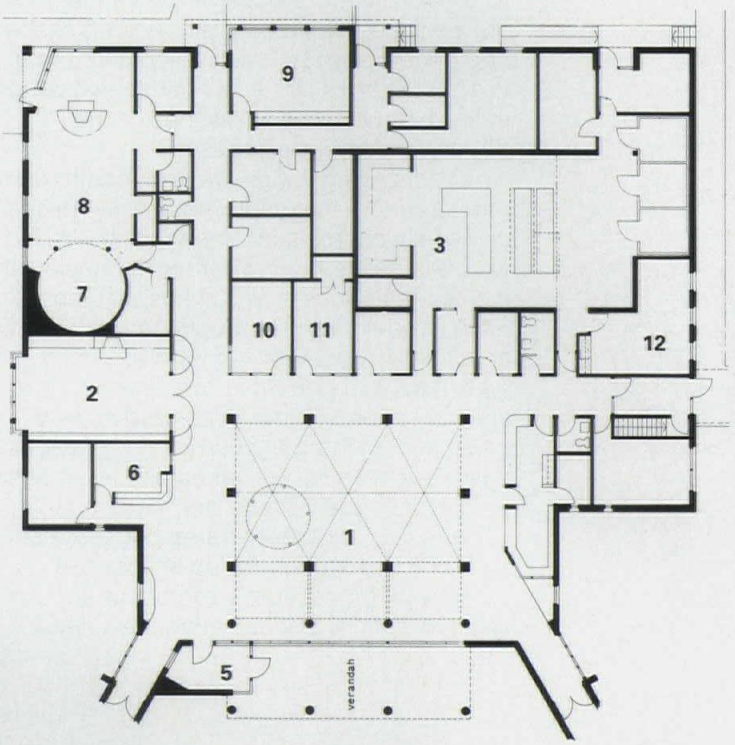
1 TOWN HALL
2 ADMINISTRATION
3 KITCHEN
4 RESIDENT HOUSE
5 MAIN ENTRY
6 RECEPTION
7 CHAPEL
8 DAY CARE
9 DAY CARE DINING ROOM
10 BEAUTY/BARBER SHOP
11 FITNESS ROOM
12 STAFF DINING
13 SITTING ROOM
14 DINING ROOM
15 OFFICE
16 TUB ROOM
17 ACTIVITY ROOM
18 DOUBLE BEDROOM
19 SINGLE BEDROOM

SITE/FIRST FLOOR PLAN

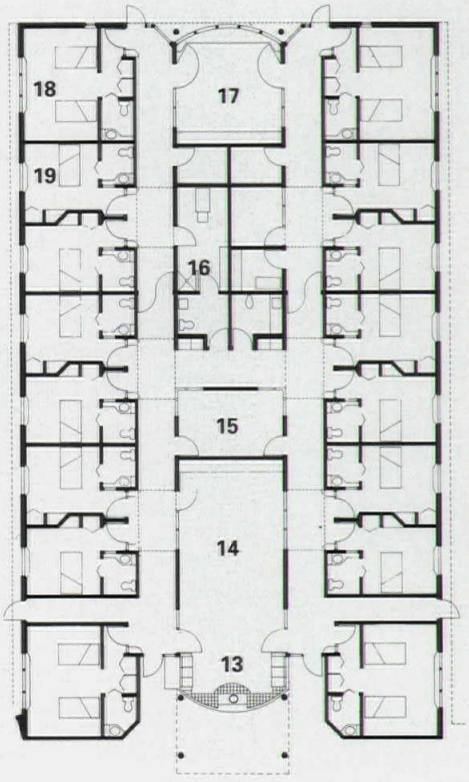
N 100'/30m



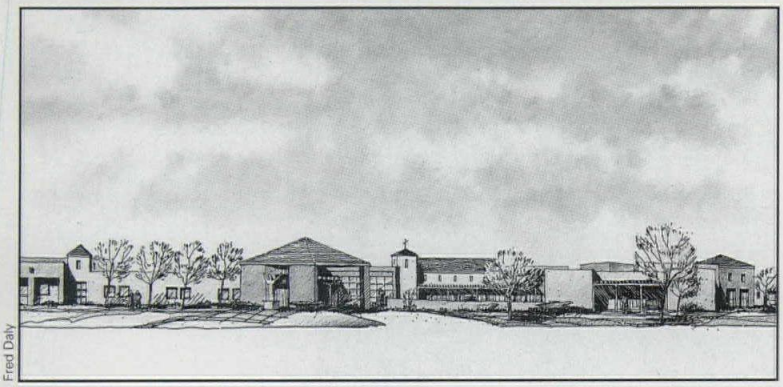
AXONOMETRIC



MAIN BUILDING FLOOR PLAN



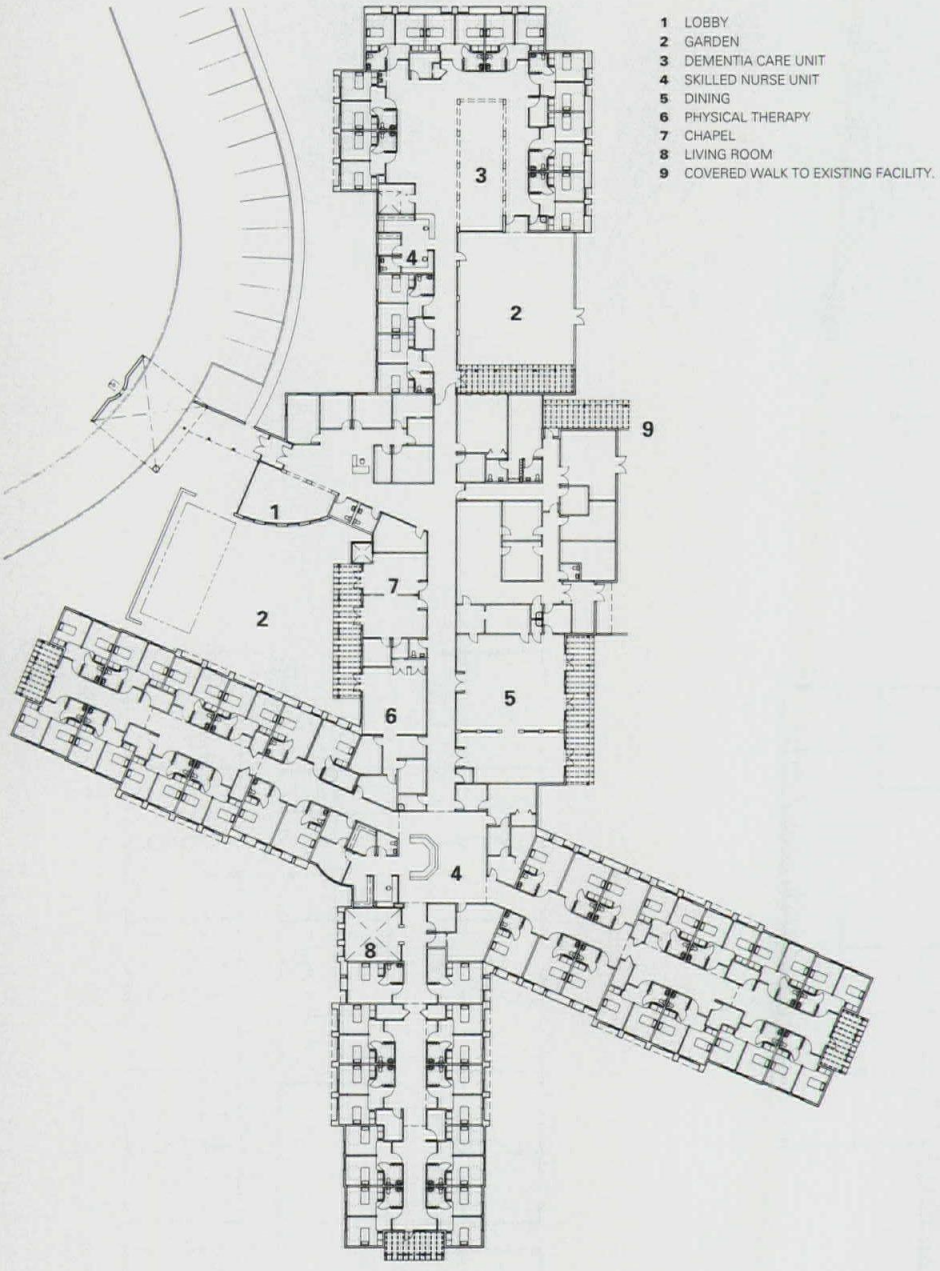
RESIDENT HOUSE FLOOR PLAN



Fred Daly

View of Entry Facade

Lea County Good Samaritan Village



FIRST FLOOR PLAN

Project: Lea County Good Samaritan Village, Hobbs, NM.
Architect: Holmes Sabatini Associates, Albuquerque, NM (William Q. Sabatini, *principal-in-charge;* Rodney Lamberson, *project manager*).
Client: Evangelical Lutheran Good Samaritan Society.
Program: 60-bed skilled nursing unit and 20-bed specialized dementia care unit.
Building Area: (net/gross, square feet) 32,000/40,000.
Cost: $75-80/sf.
Major Materials: Concrete slab-on-grade, steel frame structure, 2-part synthetic stucco finish, plaster walls.
Consultants: Coupland-Moran Engineers, mechanical/electrical; HKS Engineering, structural; Morrow and Company, landscaping; Mark Goodwin and Associates, civil; McKown Belanger Associates, interiors; Balis and Company, cost estimating.
CAD-developed? Yes.

Architect's Statement: This new facility, which will replace a heavily used collection of buildings, comprises a 60-bed skilled nursing unit and a 20-bed specialized dementia care unit. It is planned so that the existing facility can be used continuously throughout the construction process. A primary design goal was to break down the scale of the whole and create a village, with a centrally located chapel. The general layout, with walled gardens on the east side, offers a familiar spatial pattern in the flat, windswept reaches of the Southwest's permeau basin.

Resident living wings are arranged to eliminate corridors that cannot be easily reached or visually supervised. Resident rooms, in turn, are designed to offer more equality and privacy than does a typical hospital room. Each resident wing is modulated by a seating area lighted by a high clerestory.

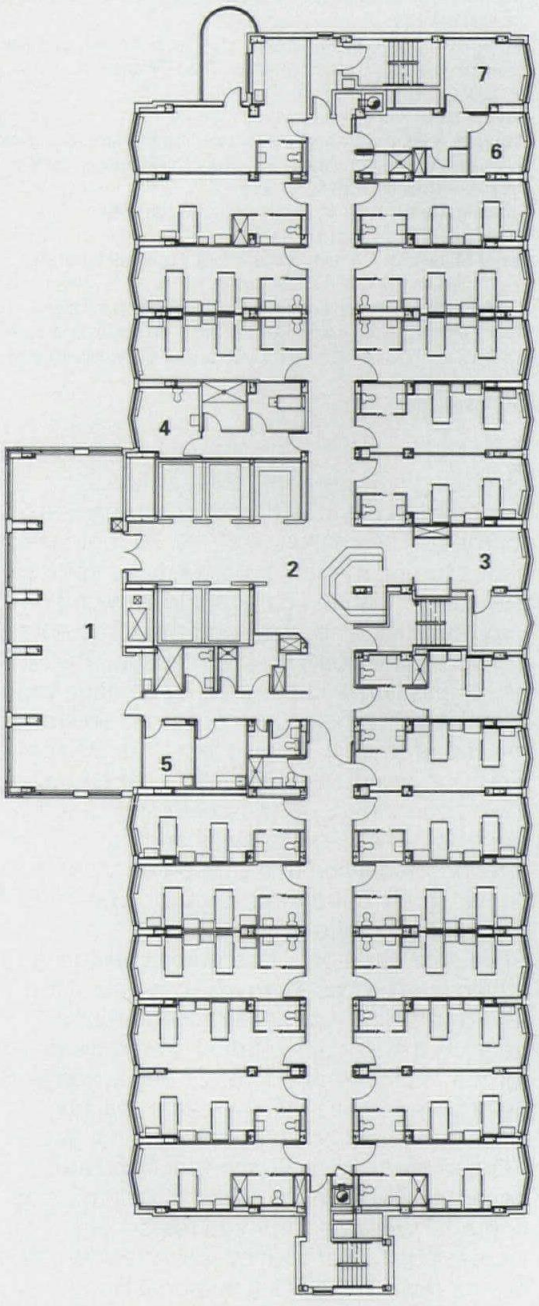
A critical component in the design is the special-care unit with centralized activity areas and an integral courtyard. It provides an easily supervised, yet varied and interesting world for residents with dementia.

The facility is of steel frame construction with stucco exterior. Living spaces are marked with pitched tile roofs that set them apart as special places within the village.

Louis Checkman

Model Showing Expanded Skilled Nursing Facility Tower and Proposed Laundry/Office Addition

Isabella Geriatric Center



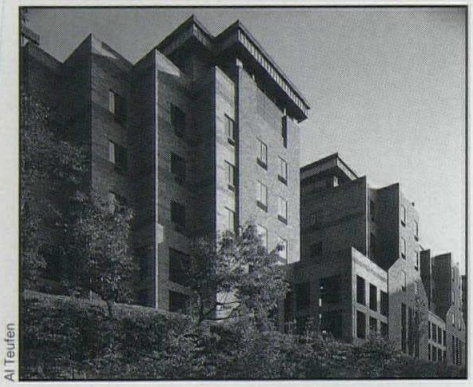
1 DINING
2 NURSE STATION
3 CHARTING
4 BATHING SUITE
5 UTILITY
6 CONSULTATION
7 RESIDENT LOUNGE

Project: Isabella Geriatric Center, New York, NY.
Architect: Ronald Schmidt & Associates, Hackensack, NJ (Kellen Chapin, *project principal-in-charge of administration;* John Chadwick, *project principal-in-charge of design;* Joel Rittvo, *project manager;* Charles Knapp, *job captain;* Christine Balint, Pat Pentland, Elaine Adia, Sibel Asantugrul, Brian Cusano, Michael Higgins, Susan Lee, *project team).*
Client: Isabella Geriatric Center.
Program: Existing 19-floor building: Conversion of six floors, currently apartments for the well elderly, to skilled nursing facility units with new group dining rooms on each floor. Renovation of the cellar, basement, first, and second floors for medical and administrative support functions.
Building addition: high production laundry, offices and seminar rooms for staff; tunnel and bridge to main building.
Existing 15-floor building: dietary and general support functions on renovated basement and second floors, plus new recreation therapy suite.
Building Area: (new construction; net/gross, square feet) 37,230/50,943. Total building area, including conversion and renovation of existing facility: 559,266 gross square feet.
Cost $30,000,000 (est. 1993).
Major Materials: Dining room addition: concrete structure, face brick on metal stud back-up, cast stone and terra cotta accents, aluminum and glass curtain wall system. Recreational therapy addition: column-free structural steel frame, face brick on metal stud back-up, cast stone and terra cotta accents, aluminum and glass curtain wall system. Laundry/office addition: structural steel frame, face brick on metal stud back-up, cast stone and terra cotta accents, aluminum and glass curtain wall system.
Consultants: Humphreys & Harding, general contractor; M.G. McLaren, structural; KFA Consulting Engineers, M/E/P; VEP Associates, site/survey; DeBellis and Semmens, landscape; Raymond/Raymond Associates, food service; Melick-Tully & Associates, geotechnical; Professional Design Group, medical equipment.
CAD-developed? 50% CAD-developed.

Architect's Statement: Upon completion, this complex will be the largest single-site nursing facility in Manhattan. The primary design challenge is to renovate the Center so that it enhances the residents' quality of life, while working with the existing building structure and rigid budget parameters. A consistent palette of exterior materials will help make this complex seem more unified. On the inside, a variety of textures, materials, colors, and furnishings will give each of the individual units and departments its own distinct character.

FLOORS 7 - 10, PLAN, SKILLED NURSING FACILITY

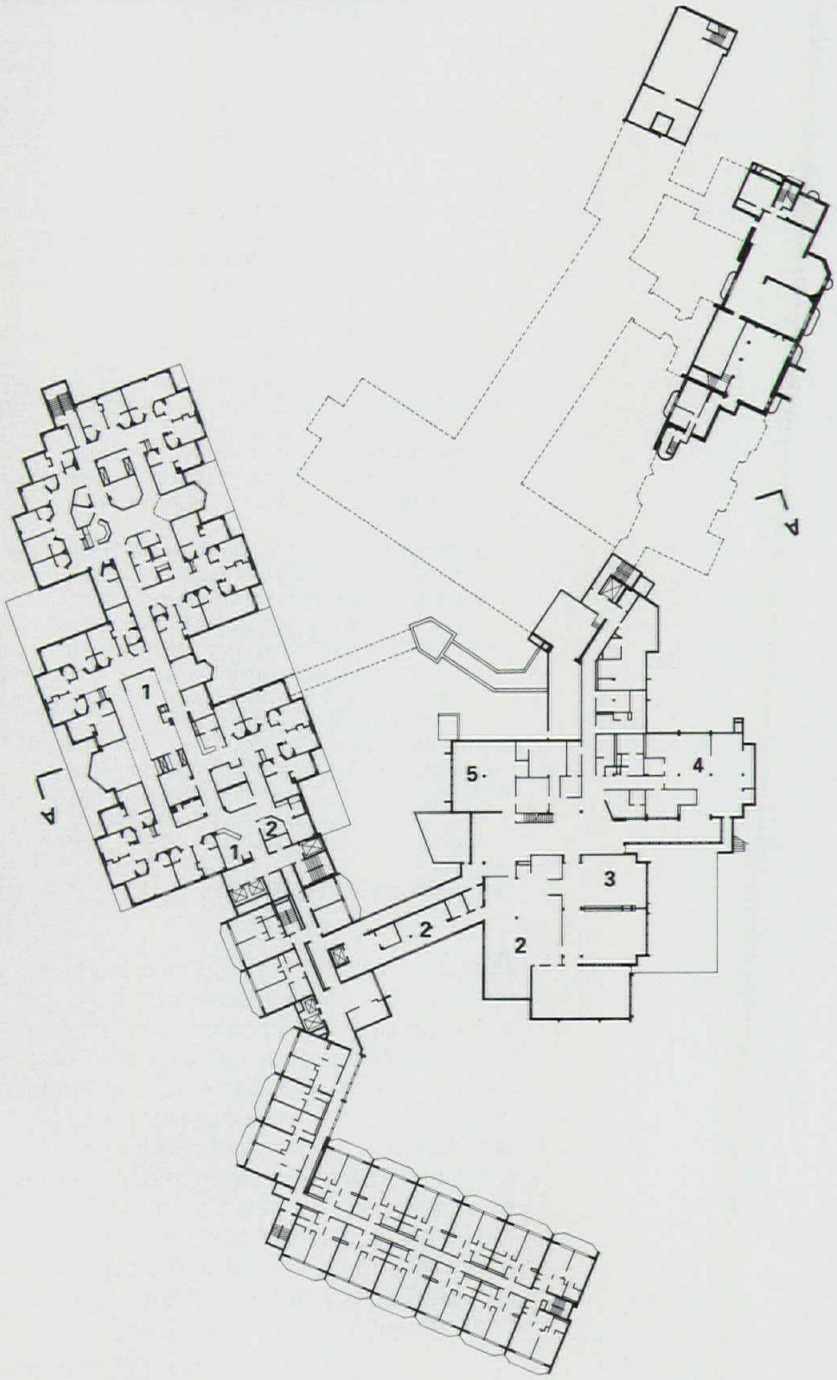
N 20'/6m



Al Teufen

Hillside View

Bruening Health Center



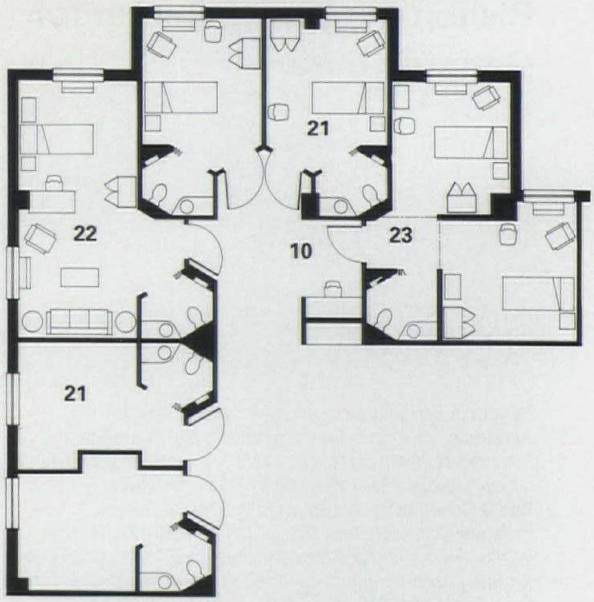
NURSING FLOOR 3

N 50'/15m

Project: Bruening Health Center, Judson Park Retirement Community, Cleveland, Ohio.
Architect: HGG, Inc., Cleveland, Ohio (James G. Herman, *principal in charge;* Randy Doi, *project architect;* David DiFrancesco, *project designer*).
Client: Judson Retirement Community, Inc.
Program: A 126-bed nursing addition to existing retirement community campus. Amenities to include a 150-car parking garage, health pavilion, and related support services.
Building Area: (net/gross, square feet) 47,250/67,500.
Cost: $91/sf.
Major Materials: Post-tensioned reinforced concrete frame and brick veneer on metal stud exterior walls.
Consultants: Barber and Hoffman, structural; Bacik Karpinski Associates, mechanical and electrical; Knight and Stolar, landscape architecture; Lorainne Hiatt, Ph.D., environmental psychology/gerentology.
CAD-developed? No.

Architect's Statement: This facility is designed to blend with the local urban environment. The challenge of the 70-foot hillside site is turned into an opportunity by setting the 150-car parking garage and service floor into the hillside and stacking the three nursing floors and health pavilion above. The health pavilion is connected by a bridge to the first floor of the existing common facilities at the top of the hill. This scheme maximizes views of downtown Cleveland, Lake Erie, and the adjacent cultural and university center from both the nursing levels and the health pavilion. Receiving and support services are conveniently but unobtrusively located below the main entrance level.

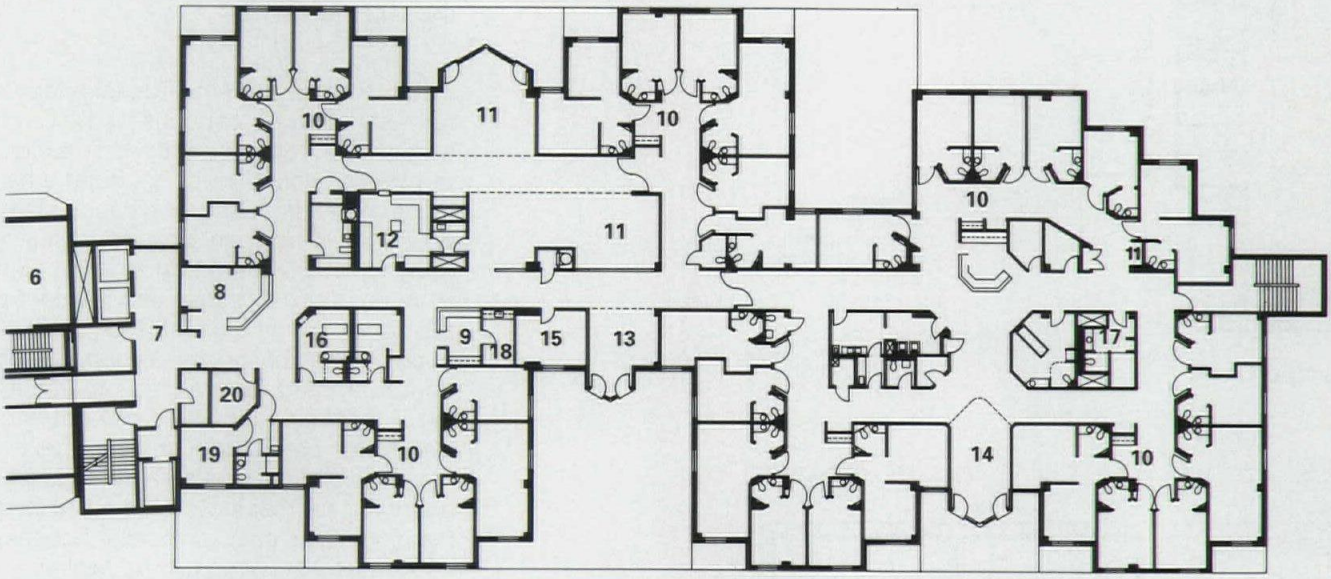
The configuration of the nursing levels is driven by plan based on a seven-bed "cluster" of resident rooms, arranged around a dedicated nurse aide station. Three clusters form a "neighborhood" of 21 beds. Each neighborhood has a team leader station, clean linen holding area, soiled utility, and tub/shower rooms. Support facilities are decentralized on each of the 42-bed nursing floors for close proximity to residents, increasing staff efficiency. Each resident floor has its own dining area, personal laundry room, program/activity space and resident lounge. The A top-floor health pavilion level is the hub of activity, providing commons facilities for the entire retirement community.



1 42 BED NURSING UNIT
2 KITCHEN
3 DINING
4 CRAFT ROOM
5 EMPLOYEE LOUNGE
6 EXISTING INDEPENDENT LIVING
7 ELEVATOR LOBBY
8 RECEPTION
9 TEAM LEADER STATION
10 NURSE AID STATION
11 DINING
12 SERVING PANTRY
13 LOUNGE/DAY ROOM
14 PROGRAM AREA
15 CONFERENCE/CONSULTATION
16 TUB ROOM
17 SHOWER ROOM
18 MEDICINE
19 ISOLATION ROOM
20 HEAD NURSE
21 PRIVATE ROOM
22 LARGE PRIVATE ROOM
23 SEMI PRIVATE ROOM
24 ASSISTED LIVING
25 DEMENTIA
26 SERVICE
27 PARKING
28 NURSING
29 HEALTH PAVILION

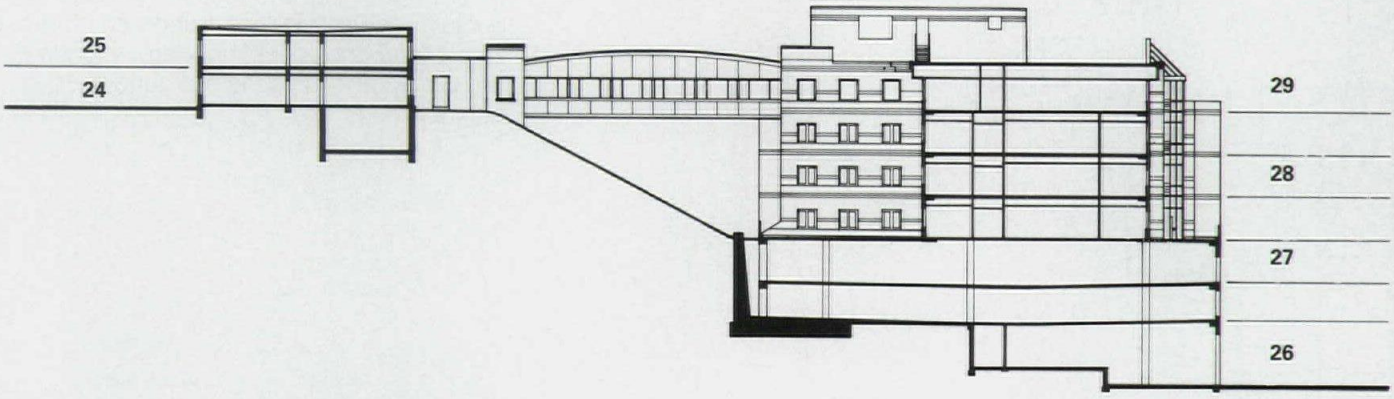
TYPICAL CLUSTER FLOOR PLAN

N → 10'/3m



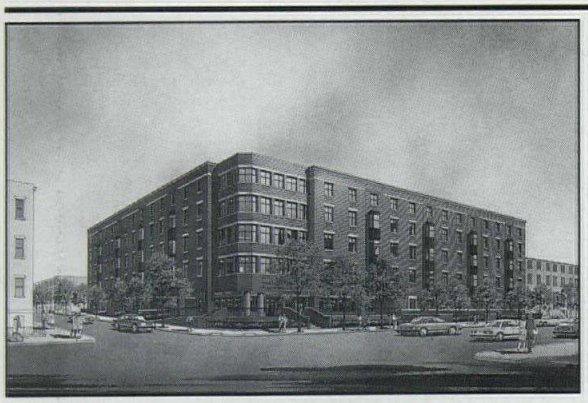
PARTIAL NURSING FLOOR 3

N → 40'/12m



SECTION A-A

N → 40'/12m

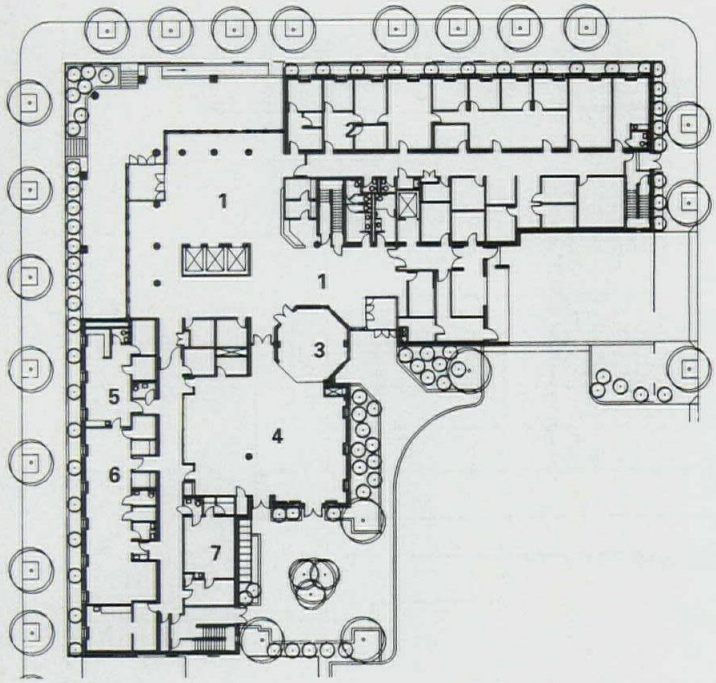


Rendering

Bishop Mugavero Center for Geriatric Care

1 LOBBY
2 ADMITTING
3 CHAPEL
4 ACTIVITY ROOM
5 OCCUPATIONAL THERAPY
6 PHYSICAL THERAPY
7 DENTIST
8 SEATING
9 LOUNGE
10 DINING/ACTIVITY ROOM
11 NURSE STATION

TYPICAL FLOOR PLAN



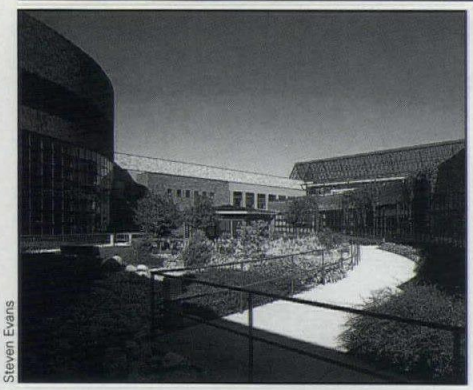
FIRST FLOOR PLAN

N 40'/12m

Project Bishop Mugavero Center for Geriatric Care, Brooklyn.
Architect: Albert Schunkewitz & Partners, New York (Albert Schunkewitz, *partner in charge;* Judith C. Mumma, *project architect;* Steven Kaunelis, Edward Lui, David Matero, *design team*).
Client: Catholic Medical Center of Brooklyn and Queens.
Program: Construct a new 288-bed skilled nursing facility on a 48,266 square-foot site in Brooklyn's Boerum Hill historical district.
Building Area: (net/gross, square feet) 86,624 /136,000.
Cost: $158/gsf (1994).
Consultants: Goldreich, Page & Thropp, structural; Lehr Associates, mechanical; Thomas Balsley Associates, landscape; Post & Grossbard, dietary; Turner Construction, construction manager.
CAD-developed? Yes.

Architects Statement: This five-floor long-term care facility responds to the Catholic Medical Center's need for more skilled long-term care beds. Slated for a tight urban site, its design must maintain existing street lines while providing open areas for residents' outdoor activities. The first floor layout includes an open public entrance and resident plaza at the corner of the main streets, while the opposite side has a private entrance for residents and staff, with a drop-off area and parking. The lobby connects these entrances; it also offers access to a small chapel and an activities and therapy area. A landscaped courtyard for residents is adjacent to the main activities area. The cellar houses dietary and support services for the facility.

The patient floor plan has two nursing units per floor; each has 36 beds. Shared dining, lounge, and public elevators are centered at a prominent corner of the site. The façade's oriel windows, window proportions, precast lintels, and brick detailing were inspired by the brownstones of the surrounding neighborhood.



Steven Evans

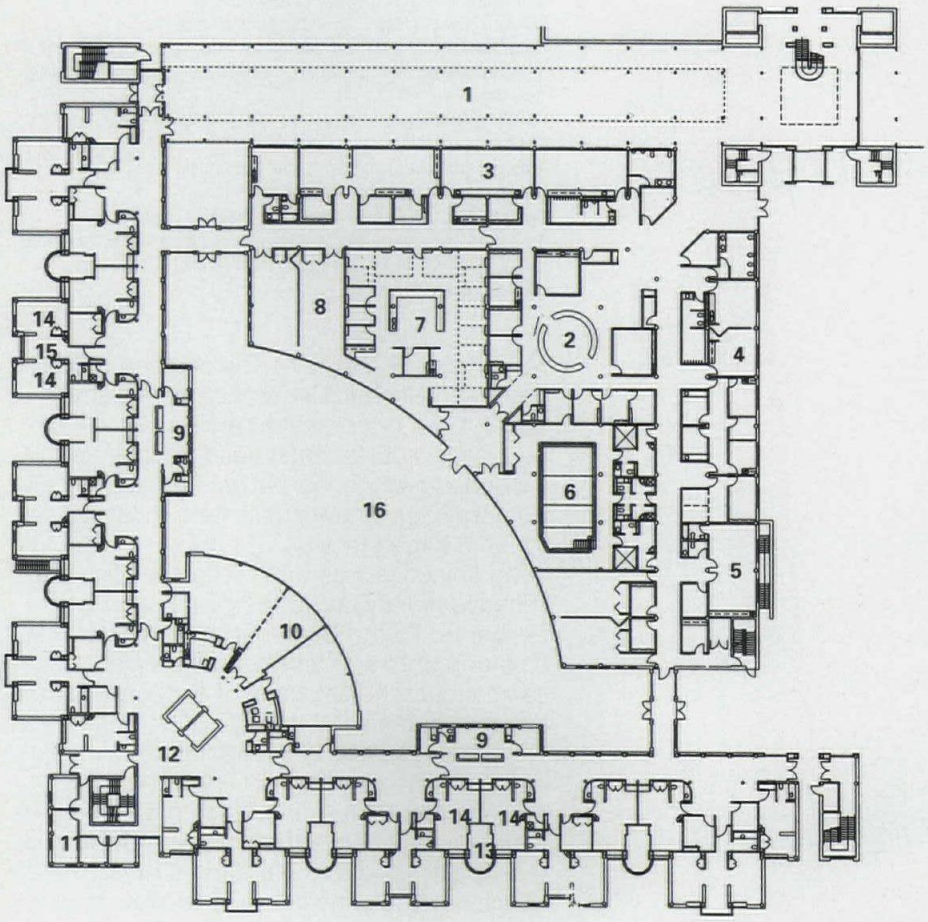
View Inside Courtyard

St. Thomas-Elgin Hospital Addition

Project: St. Thomas-Elgin General Hospital Long-Term Care Addition, St. Thomas, Ontario.
Architect: NORR Partnership, Limited, Toronto, Ontario.
Client: St. Thomas-Elgin General Hospital, Mr. J.R. Skafel, Executive Director.
Program: Add a 120-bed, long-term care facility to an existing acute-care hospital.
Building area: (net/gross, square feet) 110,000/140,000.
Cost: $520,100,000.
Completion: 1990.
Major materials: Brick cladding, aluminum windows and curtain-wall, steel frame.
Consultants: NORR Engineering Limited, structural; Vandenwestem & Rutherford, mechanical/electrical.
General Contractor: Ellis-Don Company.
CAD-developed? Yes.

Architect's Statement: This 120-bed addition to an acute-care hospital contains facilities for long-term care and rehabilitation. The architectural approach to the new addition was two-fold. First, all circulation was designed to be clear and unambiguous, assisting both the disoriented patients and the caregivers. The circulation space was designed to be a stimulating, sun-filled environment, instead of the typical institutional service core, thereby removing the oppressive stigma of a dark, closed-in corridor. The introduction of a central walkway was developed to provide a strong central spine of circulation to act as an orienting hub for future development on the site and as an animated area of activity and natural light for the use of patients, staff, and visitors to the complex.

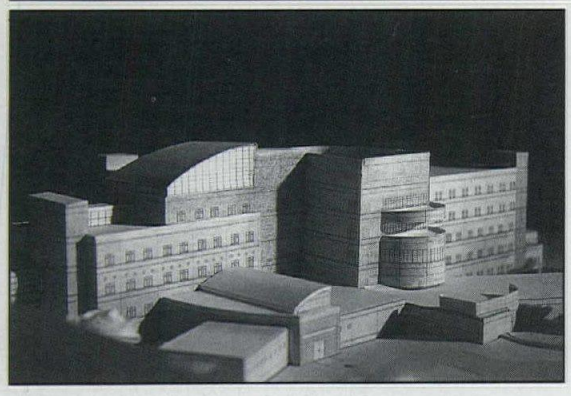
Second, pure geometries were developed to define building elements and express scale by abstracting images such as "residential vernacular" and "arcade". A language was developed by layering planes and volumes in plan and elevation against the backdrop of circulation and building edges. This has resulted in a two-story residential building, with volumes that relate closely in scale and material to the juxtaposed existing housing.



1 ATRIUM
2 RECEPTION
3 OCCUPATIONAL THERAPY
4 SPEECH THERAPY
5 DAY HOSPITAL
6 POOL
7 PHYSIOTHERAPY
8 GYMNASIUM
9 NURSING STATION
10 MULTIPURPOSE
11 OFFICE AREA
12 ELEVATORS
13 LIVING ROOM
14 BEDROOMS
15 LOUNGE
16 COURTYARD

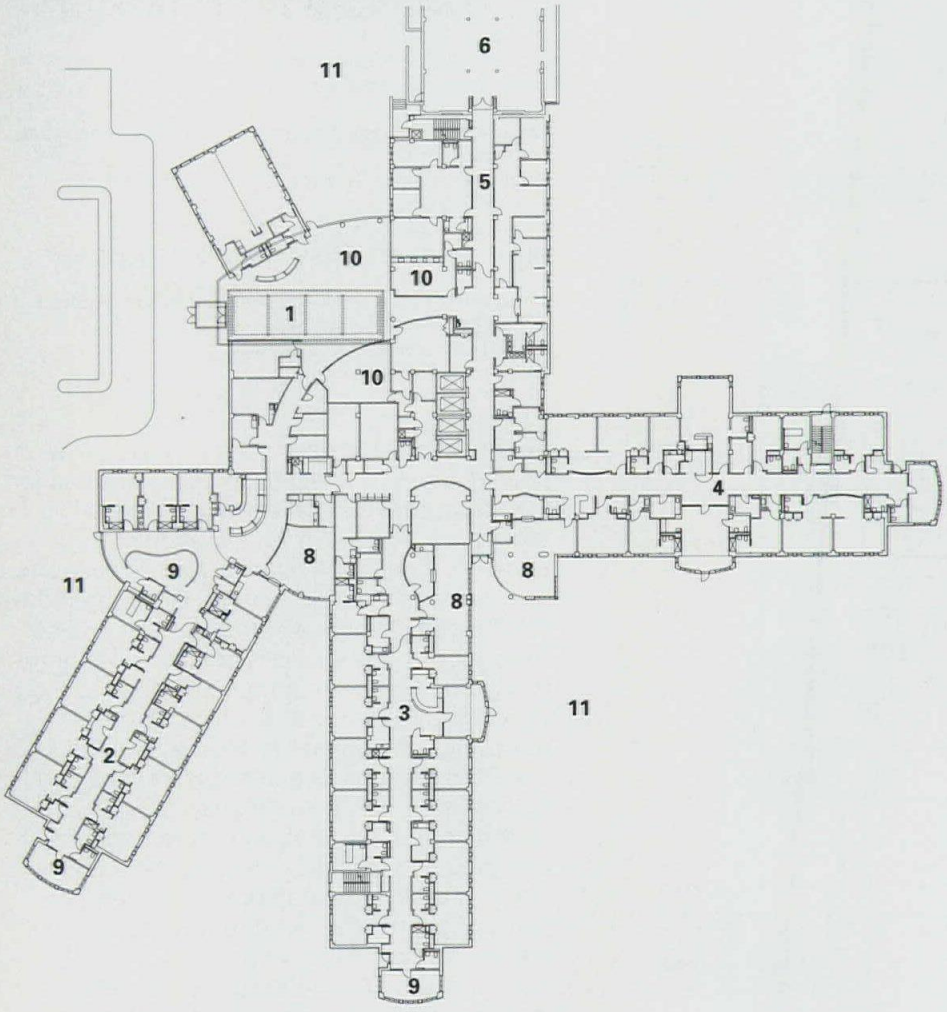
GROUND FLOOR PLAN

N ↑ 40'/12m



Model

Addition to Patterson Geriatric Center



1 LOBBY
2 AIDS WING
3 ADOLESCENT WING
4 PEDIATRICS WING
5 ADMINISTRATION
6 EXISTING FACILITY
7 MULTIPURPOSE
8 DINING
9 LOUNGE
10 ACTIVITIES
11 GARDEN
12 NURSE STATION

FIRST FLOOR PLAN

N 40'/12m

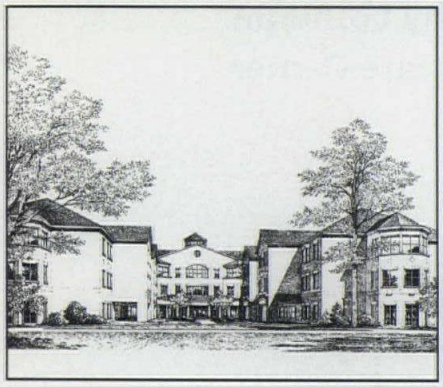
Project: Addition to A. Holly Patterson Geriatric Center, Nassau County Medical Center, N Y.
Architect: Silver & Ziskind, New York, (David Miles Ziskind, *partner-in-charge;* David J. Augustine, *project architect;* Jonathan Cohn, *architect/designer;* Dilip Ghia, Ricardo Cheng, Yolanda Costiniano, Julius Babilonia, Dan Brammer, *project team*).
Client: Nassau County, Department of Public Works.
Program: Provide a 200-bed addition to existing skilled nursing facility; new construction is primarily for specialty and rehabilitative long-term care.
Building Area: (net/gross, square feet) 155,400/193,000.
Cost: not available.
Major materials: Steel frame, split and ground-face block cladding, steel trusses, glass block, metal roof.
Consultants: STV/SSV&K, structural; Lizardos Engineering Associates, mechanical/electrical/plumbing; Gibbons Esposito & Boyce, civil; William B.Kuhl, landscape and outdoor rehabilitative areas.
CAD-developed? Yes.

Architect's Statement: The addition to the Patterson Geriatic Center comprises seven specialty long-term care nursing units: AIDS, pediatrics, adolescents, head trauma, ventilator-dependent, rehabilitative, and geriatric. It also provides a new public face for an established 900-bed facility.

The objective was to provide specific rehabilitative healthcare to the center's various residents. To this end, interior and exterior environments are designed so residents can conduct the activities of daily life in an assisted setting.

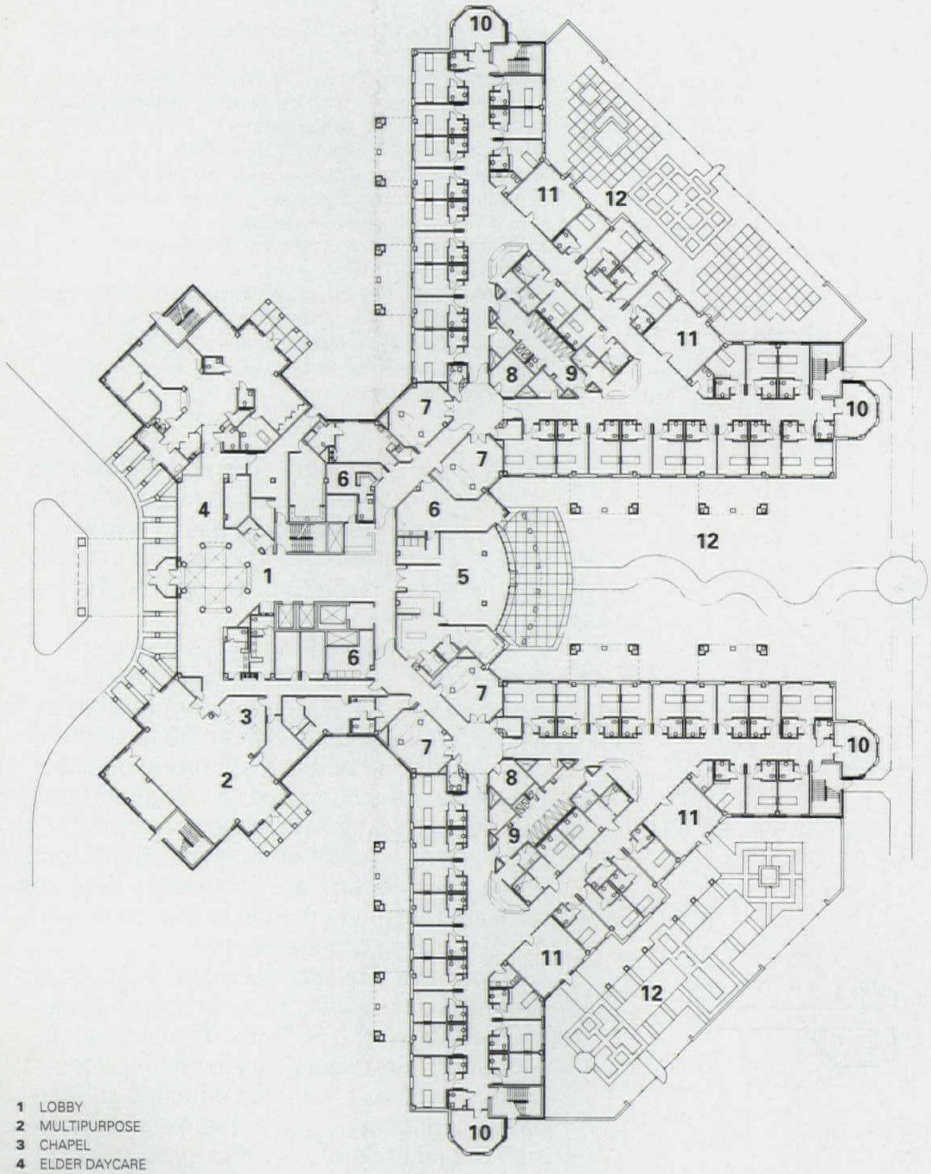
The new addition is connected to the existing facility by a three-floor link; it houses shared program support. Each program component is uniquely articulated to provide a residential scale to the entire facility.

Each nursing wing is zoned to provide outdoor space on every floor, a window at every resident's bed, and a service zone along either side of the resident room corridor. This corridor is analogous to a street, with porches at the room entrances and gathering lounges at the ends. The two-floor glazed entrance lobby provides for public and independent activities with a shopping area, snack bar, hairdresser, and performance and meeting spaces.



Rendering of Rear Courtyard

Windsor Western Hospital Long-Term Care Centre



FIRST FLOOR PLAN

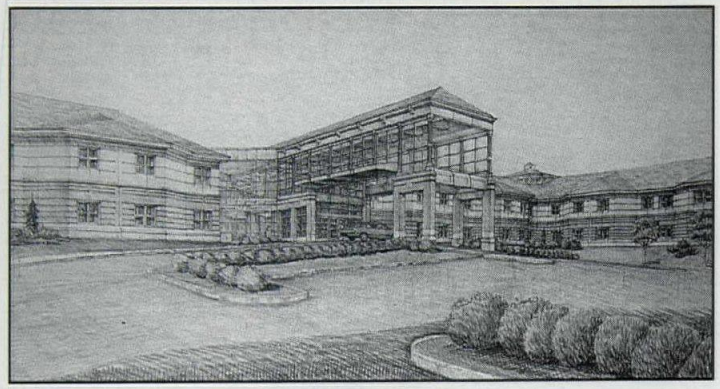
N 40'/12m

Project: Windsor Western Hospital Long-Term Care Centre, Windsor, Ontario.
Design Architect: Cannon, Grand Island, NY (J.D. Cannon, *officer in charge;* Bill Repichowsky, *project designer;* David Reichard, *project manager;* Elise Travers, Dan Schermerhorn, Dave Kaczmarowski, *design team*).
Architect of Record: Crang & Boake Inc., Don Mills, Ontario (Colm P. Murphy, *project manager;* Carl Pfister, *project architect;* Mike Allardyce, *project architect*).
Client: Windsor Western Hospital Centre.
Program: Provide a 225-bed, 185,000-square-foot long-term care facility as part of a 9-acre hospital campus.
Building area: (net/gross, square feet) 167,500/185,000.
Cost: $22,700,000 (Canadian); $121/sf (Canadian).
Major materials: Jumbo brick, shingle roofs.
Consultants: Taeko Rhodes, interiors; Leipciger Kaminker Mitelman, mechanical/electrical; Carruthers & Wallace Limited, structural; Minnich Design Associates Ltd., dietary.
CAD-developed? Yes.

Architect's statement: The Long Term Care Centre is a 225-bed, providing rehabilitative, diagnostic and evaluation services to patients, plus out-patient rehabilitation services and elder daycare.

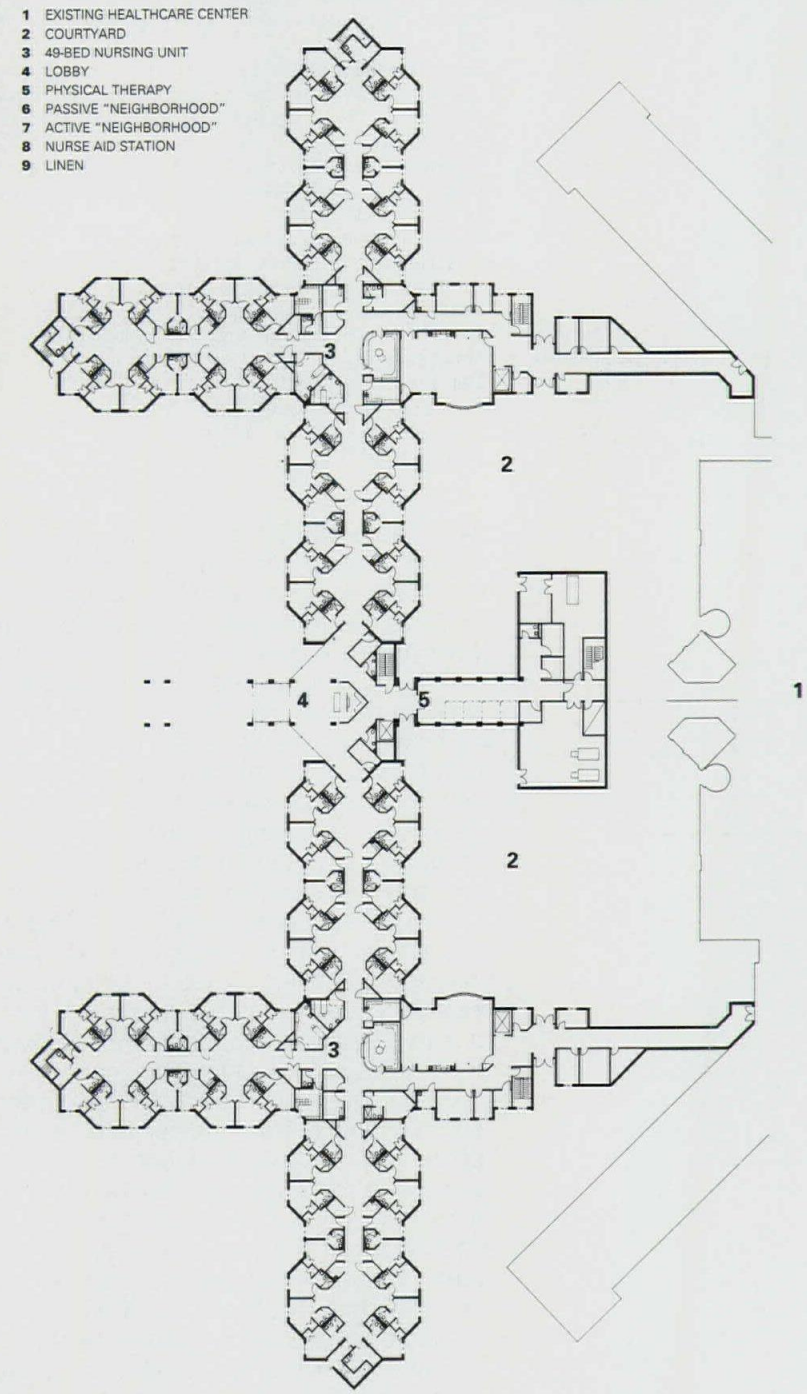
In developing the plan, we emphasized the concept of resident's "homes" within "communities" and the beneficial effect of daylighting and views to the outdoors to create an informal, non-institutional atmosphere. Patient floors are organized with a central day activity block at the heart of the building and triangular bedroom wings on either side. Within the residential wings, the triangular circulation paths of the corridors will provide interesting walking routes for patients as well as serving as the "street" to their private quarters. Nursing support areas occupy the core of the patient room block.

As in a home, public activities take place at the entry, away from the "private" quarters of the nursing units. Adjacent to the main and elevator lobbies are spacious lounge and multi-purpose areas so the patients may either observe or participate in the activities around them. Individual lounges are provided for each unit to encourage a sense of community among the residents and separate dining facilities to combat the impersonal quality often associated with institutional food service.



View of Entrance

Bethany Lutheran Healthcare Center



LOWER FLOOR PLAN

Project: Healthcare Center Expansion, Bethany Lutheran Village Centerville, OH.
Architects: Lorenz & Williams, Cincinnati and Dayton, OH (James W. Harrell, *design principal;* Richard M. Roediger, *managing principal;* John H. Westenkirchner, *project architect*).
Client: Lutheran Social Services of Miami Valley.
Program: 176 replacement beds plus 20 new beds of skilled nursing care added to an existing skilled nursing facility. Existing support services will accommodate the new spaces.
Building Area: (net/gross, square feet) 68,048/105,446.
Cost: $80.18/GSF (1993).
Major Materials: Brick and acrylic plaster exterior, gypsum board and metal stud partitions, gypsum board and acoustical tile ceilings,wood and metal windows, asphalt shingle roof.
Consultants: Heapy Engineering, mechanical and electrical.
CAD-developed? Yes.

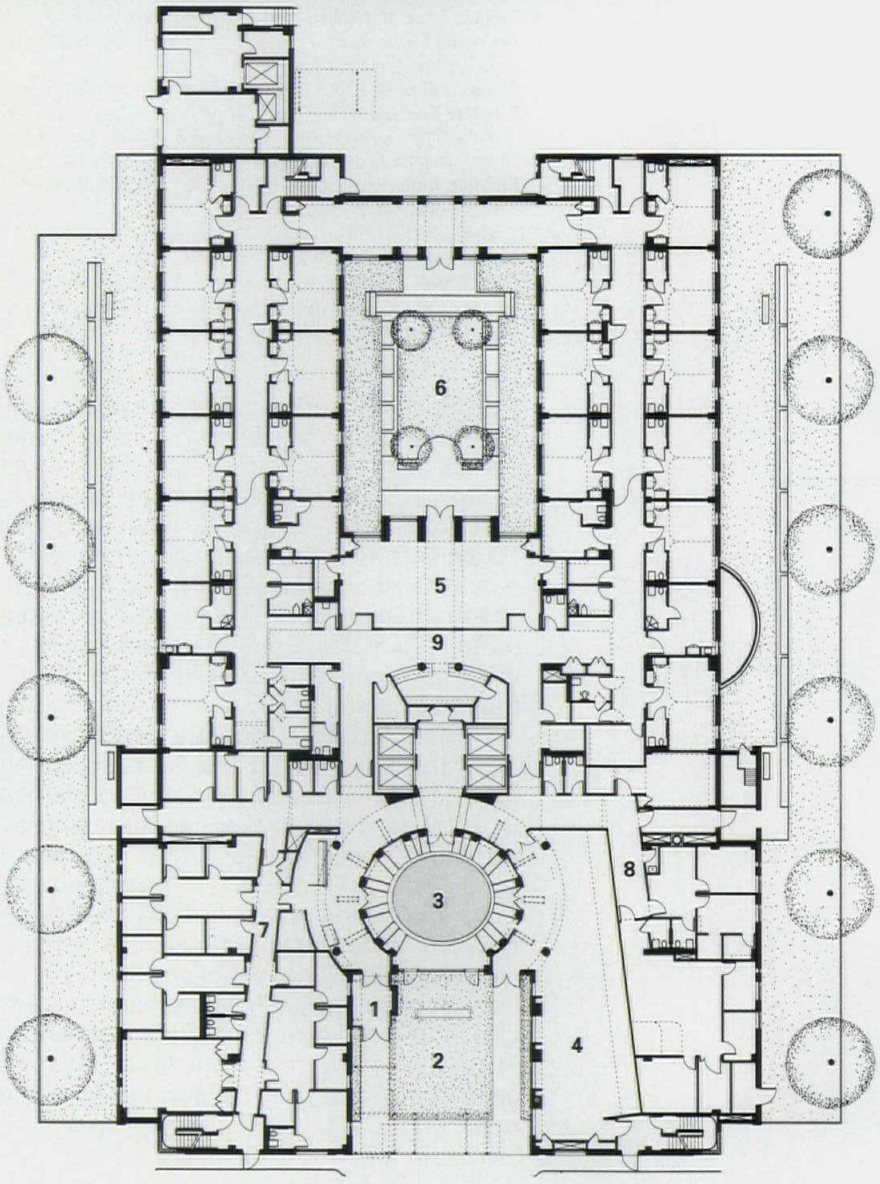
Architect's Statement: The client asked the architects to develop a clear sense of entry for the facility, to reduce the length of corridors in the resident living area, and to create an environment that would enhance the nursing programs.

The plan is tailored to the client's operational model, with a ratio of one nurse aide per eight residents. The nursing ratio on the night shift was not to exceed 50 residents for each registered nurse. Each group of eight resident rooms comprises a "neighborhood" served by a nurse aide station. Two neighborhoods form a "pod" or wing for 16 residents. Three pods, in turn, are arrayed around a center core containing the nurse station and other central program elements.

To maintain a residential scale, the building is only two floors tall; two nursing units are stacked, providing 98 beds. The program is contained in two buildings joined by a central spine, which has the main entrance and the public connection back to the existing building. The junction of new and existing buildings features two exterior courtyards, secure places where residents can enjoy the outdoors.

Rendering

Marcus Garvey Skilled Nursing Facility



1 ENTRY
2 COURT
3 ATRIUM
4 MULTIPURPOSE
5 ALZHEIMER'S DINING
6 COURTYARD
7 ADMINISTRATION
8 RESIDENT CARE
9 ALZHEIMER'S UNIT

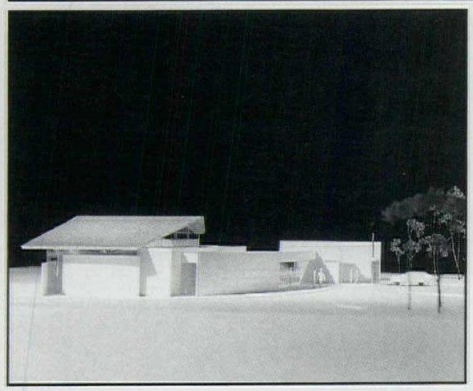
FIRST FLOOR PLAN

N ↑ 40'/6m

Project: Marcus Garvey Skilled Nursing Facility, Brooklyn.
Architect: Perkins & Will, New York, (Architecture: Donald Blair, *principal in charge;* Mark Chen, *design principal;* Kevin Perry, *project manager;* Deepika Ross, *project architect;* Chan Byun, *project designer;* John Gerney, Jen-Suh Hou, Elizabeth Pacheco, and Fariba Makooi, *project team.* Interiors: Neil Frankel, *principal in charge;* Tama Duffy, *project manager;* Deepika Ross and Joyce Afuso, *project designers*).
Client: Marcus Garvey Nursing Home, Brooklyn, NY.
Program: New 280 bed skilled nursing facility composed of six nursing units and one Alzheimer Unit, with requisite diagnostic, treatment, and therapy spaces, as well as dining rooms, activity space (interior and exterior), an activity atrium, administrative offices, food service and housekeeping facilities.
Building Area: (net/gross, square feet): 90,500/150,000.
Scheduled for completion: 1995.
Cost: $152/sf (estimate, not including furniture or group II equipment).
Major Materials: Steel frame; two shades of brick in concrete masonry cavity wall, with ground-face concrete masonry banding and architectural precast trim; painted aluminum windows and curtain wall; glass block and painted steel at stair towers.
Consultants: Salmon & Associates, structural; Khawaja & Dunne, mechanical, electrical, and plumbing; Romano Gatland, food service; D.T.M. Inc., elevator; Turner-Blakel Joint Venture, construction management.
CAD-developed? Yes.

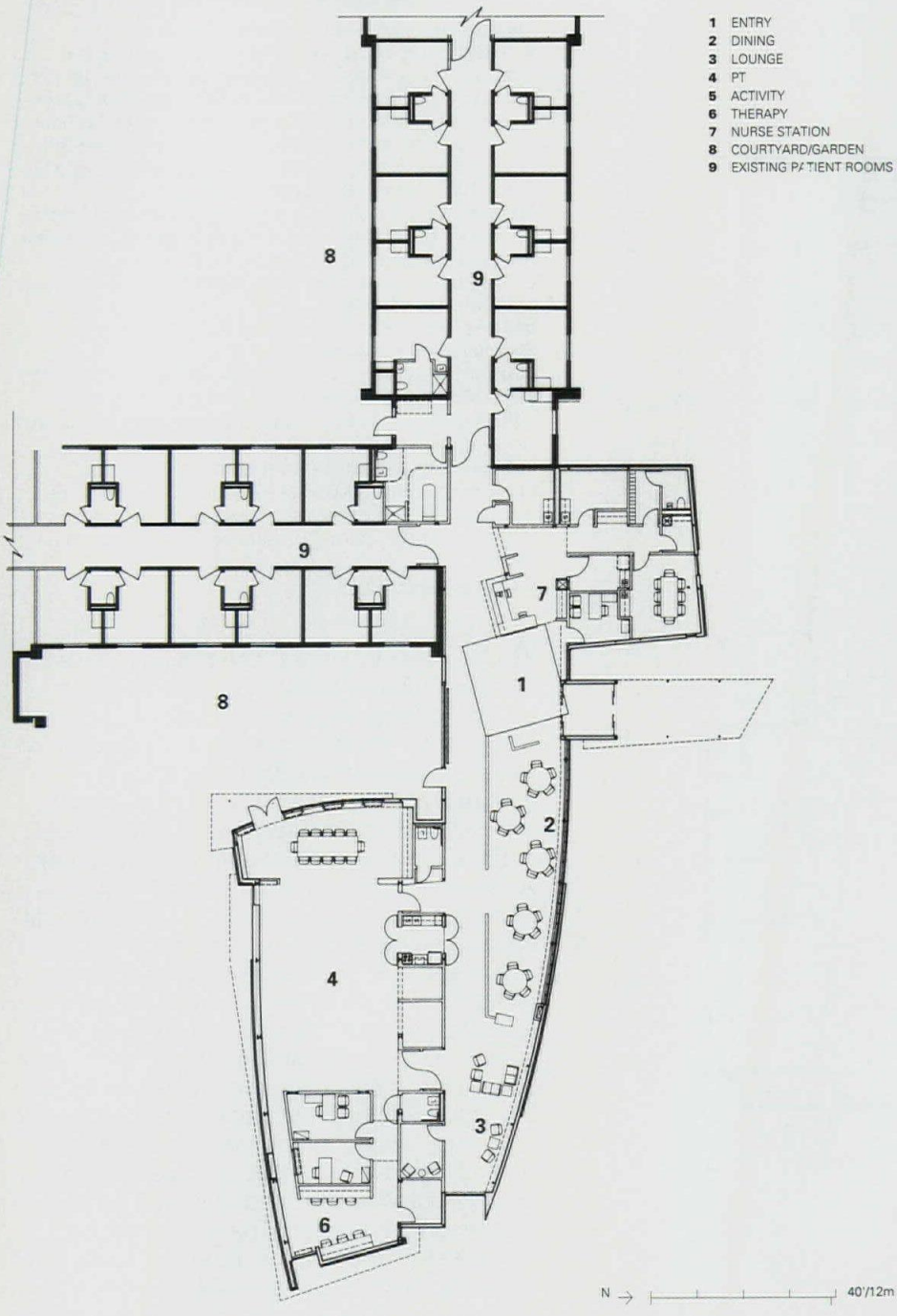
Architect's Statement: The Marcus Garvey Nursing Home is a 280-bed skilled nursing facility housing an Alzheimer unit on the ground floor and two nursing units on each of the second, third, and fourth floors. The administrative spaces are located in one of the wings of the building on the ground floor and the medical support spaces in the other. All other support spaces including kitchens, laundry, staff dining, storage, and mechanical spaces are located in the basement.

Conceptually, the resident rooms are organized in two bars between which are inserted a series of exterior and interior communal spaces. On the typical floors these communal spaces include a dining room overlooking the courtyard, and activity spaces overlooking the four story atrium. The Alzheimer unit on the ground floor varies in that it wraps around the courtyard and is designed to permit continuous circumambulation. The bi-axial double room was chosen as the repetitive room type because it allowed each resident access to more light and air while minimizing the overall depth required.



Model, Head Trauma Rehabilitation Facility

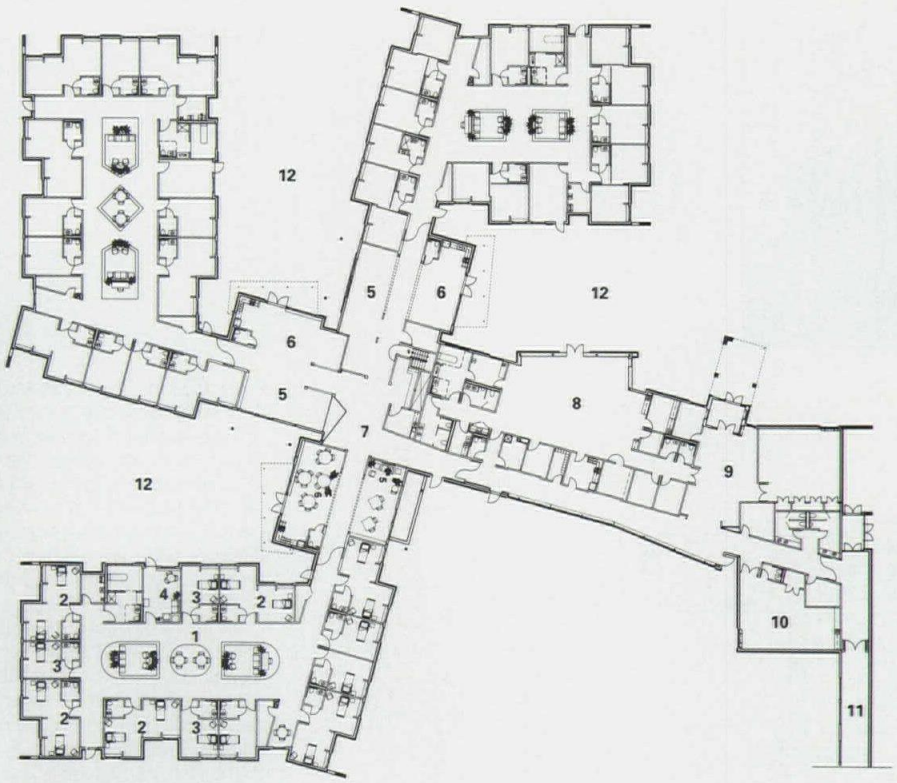
St. Johnland Nursing Home



Project: St. Johnland Nursing Home, Kings Park, NY.
Architect: Ellerbe Becket Architects & Engineers, P.C., New York (Dale Tremain, Laura Ettelman).
Client: The Society of St. Johnland (Joan Wood, Mary Jean Webber).
Program: Two additions to an existing 150-bed skilled nursing facility, including the 50-bed John P. Kipp Pavilion for Alzheimers/dementia patients and the 20-patient Head Trauma Rehabilitation Facility.
Building Area: (gross square feet) 47,000 for Kipp Pavilion and 7,000 for Head Trauma Facility.
Cost: $7,000,000 (1994).
Major Materials: Steel frame structure, brick, and stucco.
Consultants: George Langer & Associates, mechanical/electrical; Stanley Goldstein, structural; and Dana Helper, landscape.
CAD-developed? Yes.

Architect's Statement: This proposal for two new additions to the existing nursing home on the campus of the Society of St. Johnland in Suffolk County, Long Island, includes a nursing unit for Alzheimers and other dementia patients and a rehabilitation center for head trauma patients. The 50-bed nursing unit, named the John P. Kipp Pavilion, is organized in clusters around landscaped courtyards, providing a more decentralized and thus less institutional living environment than is typically found in long-term care facilities. Residents are grouped in clusters according to their specific needs and stages of dementia, allowing different types of care to be provided. The second addition, for the care and rehabilitation of patients with head injuries, also includes the renovation and expansion of the complex's existing kitchen; it will service new and existing residents and staff. The New York State Health Department has designated the additions as a "Demonstration Project" to study innovative design approaches on the housing and care of nursing home residents.

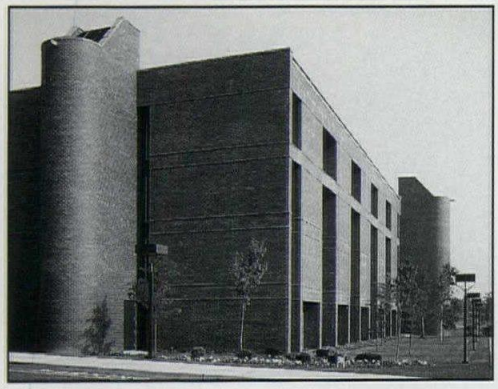
HEAD TRAUMA REHABILITATION FACILITY, GROUND FLOOR PLAN



1 CLUSTER LOUNGE
2 TWO-BEDROOM
3 ONE-BEDROOM
4 QUIET LOUNGE
5 ACTIVITY
6 DINING
7 ATRIUM
8 DAY CARE
9 MAIN ENTRANCE
10 PT/OT
11 LINK TO EXISTING BUILDING
12 COURTYARD/GARDEN

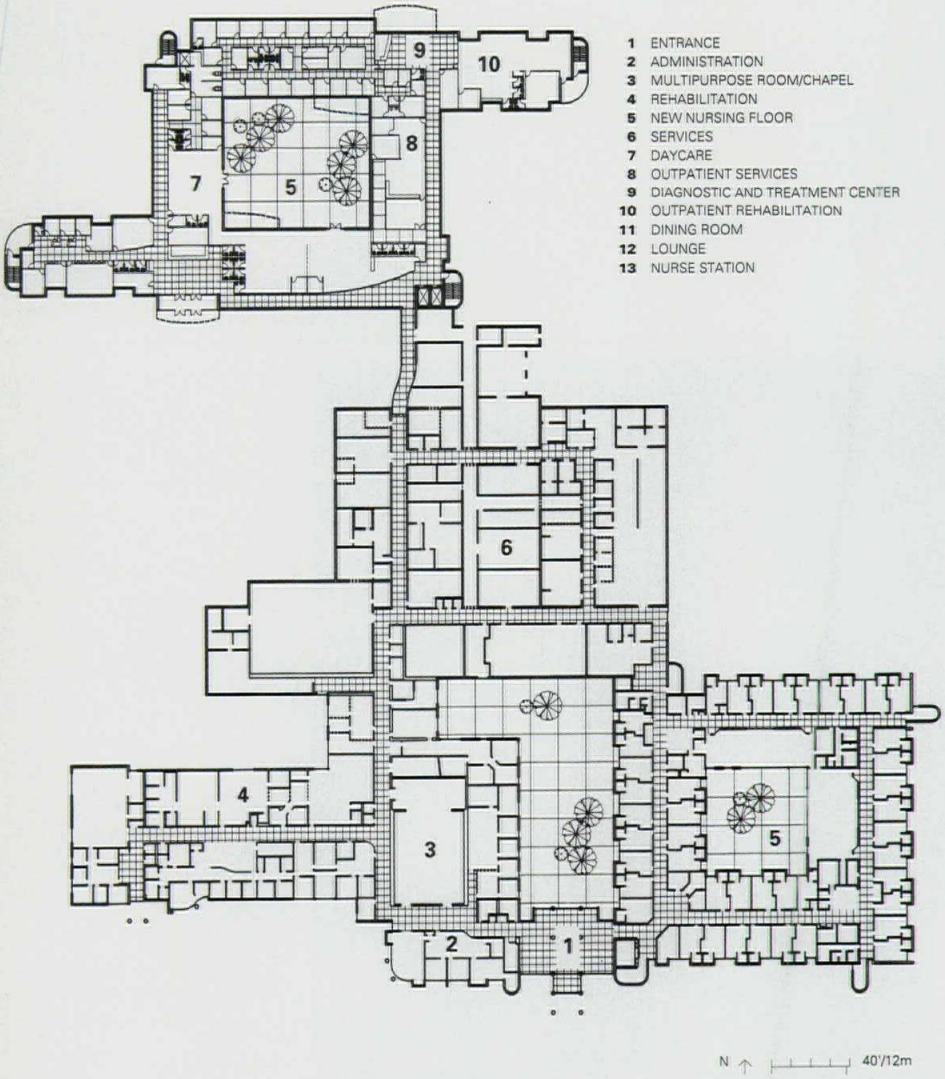
JOHN P. KIPP PAVILION, FLOOR PLAN

N → 40'/12m



View of Nursing Units

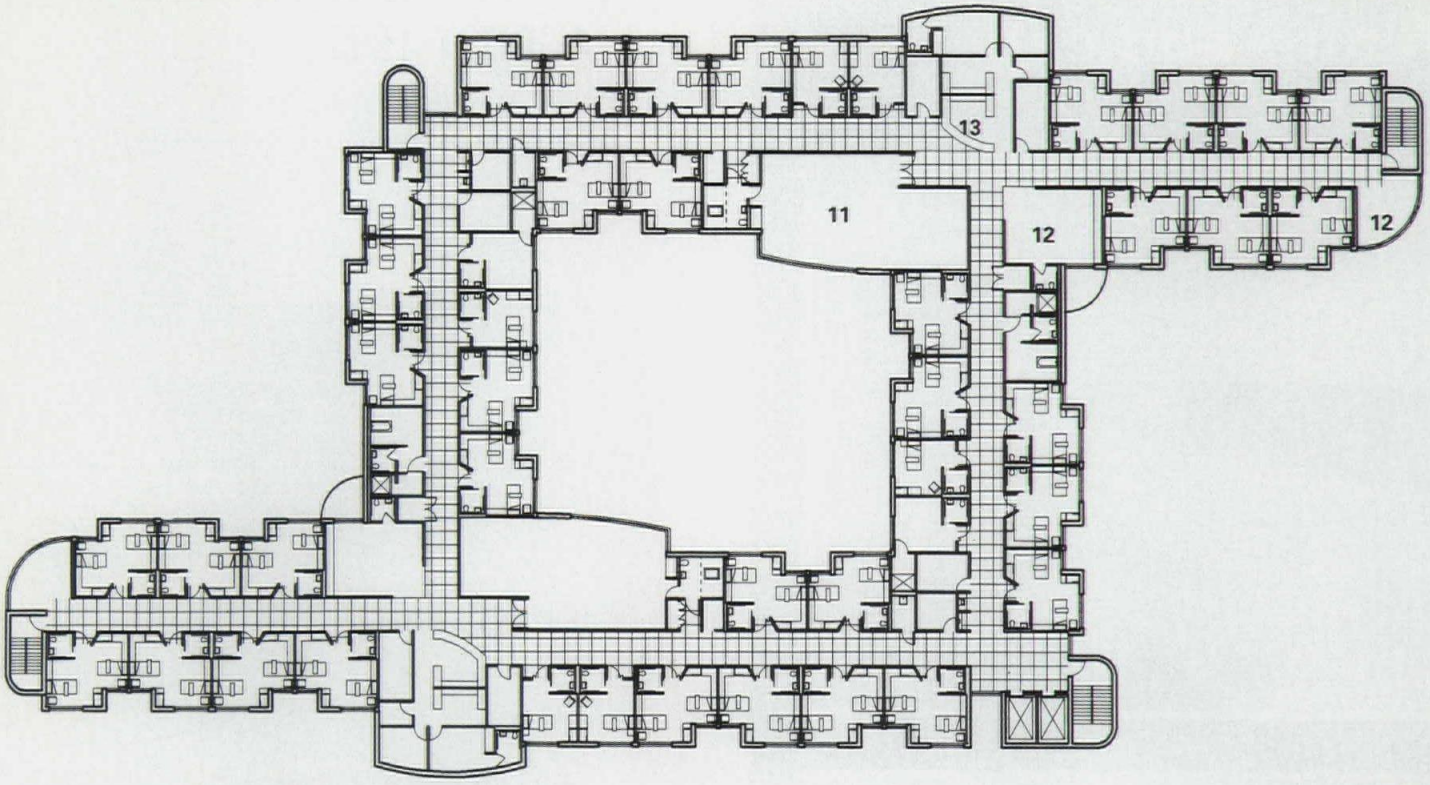
Gurwin Jewish Geriatric Center



GROUND FLOOR PLAN; NEW NURSING FLOORS ANNEXED ON EAST AND NORTH SIDES

Project: Gurwin Jewish Geriatric Center, Commack, NY.
Architect: Landow and Landow,Lake Success, NY (*Original building design team:* Lloyd J. Landow, *principal in charge, project designer;* Daniel Zito, *project manager;* Anthony Marino, William Cook, Robin M. Landow, Marc J. Landow, *project team. Expansion building design team:* Lloyd J. Landow, *principal in charge, project designer;* Marc J. Landow, Glen J. Landow, Lester Katz, *project team*).
Client: Gurwin Jewish Geriatric Center.
Program: Original building: Adaptive reuse of 50,000 square feet of an existing school plus 100,000 square feet of new construction to create a 300-bed residential healthcare facility (RHCF) and a 60-participant adult day healthcare program. Expansion program: A 160-bed addition to the original 300 bed RHCF, plus expansion of the adult day health care program to 120 participants, addition of a diagnostic and treatment clinic, and a comprehensive outpatient rehabilitation facility.
Building Area: (net/gross, square feet) Original building: 100,000/150,000; Expansion: 70,000/104,000.
Cost: not available.
Major Materials: Brick and CMU masonry exterior bearing walls, steel columns, and beams, and bar joists, metal deck and concrete slab construction, tinted insulated glazing with flouropolymer coated aluminum tilt/turn operable units in all resident rooms.
Consultants: Original building: Fischer and Redlein, structural; Robert L. Cahn Associates, food service; Goldberg and Rodler, landscape design.
CAD-developed? Expansion, yes; original building, no.

Architect's statement: The Gurwin Jewish Geriatric Center sits on a ten acre suburban campus formerly occupied by an elementary school. For the original building, economic considerations mandated the adaptive use of the existing school's structure. Analysis of the program and the school's footprint on a sloping site dictated that the resident rooms, dining, and nursing areas be located in a new four-story structure linked to the former school building at its second floor. The existing structure was redesigned to house support areas and services including business offices, occupational and physical therapy, and medical suites. A new one-story wing housing the lobby, a lounge, and an executive suite was designed as a glass enclosed entrance linking the two structures. The linkage of the buildings allowed for the creation of gardens and atrium areas that provide secure and controlled areas for outdoor recreation. The design of the building requires the residents to pass by these areas, thus helping them to remain aware of their surroundings and the activities taking place.



TYPICAL NURSING FLOOR PLAN, NORTH ANNEX

N 40'/12m

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