CUSTOMER SATISFACTION IN DINING EXPERIENCE IN CONTINUING CARE RETIREMENT COMMUNITIES AND RETIRMENT COMMUNITIES

by

HEATHER GENERALI

B.S., Kansas State University, 2000

A THESIS

submitted in partial fulfillment of the requirements for the degree

MASTER OF SCIENCE

Department of Hospitality Management
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2010

Approved by:

Major Professor
Dr. Carol Shanklin

Copyright

Abstract

Aging has become a focal point for several segments of the foodservice industry with the forecasted trends. Due to the link between quality of life and satisfaction with food in this population, many Continuing Care Retirement Communities (CCRCs) and retirement communities are employing individuals who have experience in the hotel/restaurant industry. The purpose of the study was to assess residents' overall satisfaction with quality of food and quality of service in Continuing Care Retirement Communities (CCRC) and retirement communities when the facility employs a foodservice director or chef with culinary training or expertise. The research compared satisfaction based on types of foodservices provided (restaurants and café/bistros); resident characteristics such as gender and length of time residing at a facility; frequency of interaction with the chef or foodservice director; and meal plan requirement. The study was conducted in the Midwest region and included a convenience sample of Retirement Communities and CCRCs in Kansas, Missouri and Nebraska. The variables analyzed were quality of food, quality of service, atmosphere, dining venues, meal plans, and frequency of dining with overall satisfaction.

Atmosphere, food quality, dining venues, and meal plans significantly influenced overall satisfaction. Residents in facilities that provided more than one dining option had a slightly lower satisfaction ratings compared to the group who had one dining option. Overall satisfaction ratings for meal plan indicated that the respondents were neutral relative to the affect of meal plan and their overall satisfaction. The frequency of dining in one of the venues was positively influenced by meal plan requirements in the facilities. Residents who had lived in the facilities less than two years rated satisfaction higher. The more frequent the chef and foodservice

manager interacted with the residents the higher the rate of overall satisfaction. Foodservice directors and administrators in these facilities can use the results to understand what the customers are seeking and how to improve overall services for their residents.

Table of Contents

List of Tables

Acknowledgements

I am so thankful to so many individuals that supported me and helped me through completing this project. I first want to thank my husband Kris. He has supported me throughout the last four years of completing my degree and provided me the strength to push through. To Kaitlyn and Tyler, my beautiful children, your patience while I worked so many hours to accomplish this goal is amazing. I would like to thank my family for all the support they provided especially my mom and sister who helped input data and review my work at the very end so I could finish. Mom, you were always there when I needed you the most. Thank you to Willie and the Meadowlark team for the support and encouragement to focus and finish.

I would like to thank Dr. Carol Shanklin my major professor. You are a true mentor to me and kept me on track through it all. I am forever grateful. Thank you to Dr. Elizabeth (Betsy) Barrett and Dr. Kevin Gwinner for being on my supervisory committee. Dr. Barrett has been a mentor to me for the last ten years and huge support to advancing my education. Thank you to Pei Liu and Eric Mann for your support on the statistical analysis.

CHAPTER 1 - Introduction

Aging has become a focal point for several segments of the foodservice industry with the forecasted trends. The number of meals consumed in restaurants by older adults has increased at a higher rate than the entire U.S. population (Kim and Almanza, 2001). Jang, Ham, and Hong (2007) found that 68% of the seniors in their study consumed meals outside the home and spent 25% of their income on those meals. This population is more likely to eat at family dining and buffet cafeteria style restaurants, but is increasing the frequency they dine in both fine dining restaurants and casual dining (Leahy, 2007).

The number of Americans over the age of 65 was approximately 38.9 million as of 2008, representing 1 in 8 Americans. This segment of the population is predicted to increase to 72.1 million by 2030 or 19.3% of the population (Administration on Aging [AOA], 2009). It is important for foodservice managers to understand the generations that will be over the age of 65 by 2020 to help predict the type of service delivery that will be needed.

As the population of individuals over age 65 increases, there will be a higher demand of services for the foodservice segment. Compared to previous generations, today's older adults have more experience with a wide variety of foods as they travel more (Friedland, 2000). Older adults are starting to focus more on the type of food they are purchasing and the benefits they will obtain from these purchases (International, 2001). Food projects value within this population (Briley, 1994), which can play an important role in where and what they eat on any given day, or even where they choose to live.

To optimize independence, productivity, and quality of life, older adults are searching for different living options (Fox, Brummit, Ferguson-Wolf, Abernethy et al., 2000; Kellogg, 2009). Older adults are looking for choices in living that can help maintain their independence. But,

they want assurance that if they become ill, they will be taken care of by their community rather than placing the burden on their children (Groger and Kinney, 2006; Kellogg, 2009). To help provide this type of living, many older adults are looking to Continued Care Retirement Communities (CCRC) and retirement communities to meet this need. A CCRC is defined as a living arrangement that enables residents to continue to live in a planned community in one of three primary living options including independent housing, assisted living, and healthcare (Senior Resource Alliance, 2008). Retirement communities provide services for independent living only, but many of the services offered in retirement communities are the same as in CCRCs (AAHSA, 2010).

The demand for CCRCs will grow substantially over the next 20 years with the projected growth of individuals over the age of 65 years. Services and amenities are the primary focus for residents who are researching CCRCs as potential places to live (Jones, 2009). One of the services that individuals want in CCRCs is the quality of onsite dining facilities (Buzalka, 2005; Jhaveri, 2006). Typically, residents living at a CCRC have several dining options which include preparing food in their own home, eating in the community, or dining at their facility (Lee, Shanklin, and Johnson, 2003). The community atmosphere provided by CCRCs helps prevent apathy, depression, and appetite impairment, all of which impacts the quality of life of individuals (Baker, 2007). This segment of the population is a $1.47 billion market for foodservice operators (King, 1999).

With the goal of providing a spectrum of services, CCRC operators should provide a high-quality experience for individuals who currently live in the CCRC and to attract younger seniors to move to a CCRC at an earlier age. Meeting the needs and expectations of the residents will be important to maintain customer satisfaction. It is important for managers to understand

that the generation which will be 65 by 2020 will predict what is needed in the future in CCRC foodservices. The three generations impacted are the GI generation, Silent generation, and Baby Boomers. In many CCRCs, the current age group falls into the GI generation and Silent generation. Both of these generations have their own unique personality which can impact the type of service expected in CCRCs (Brandon and Flury, 2009; Buzalka, 2005). As each of these generations share the same community, demand will be placed on the foodservice operation to provide quality meals that meets the needs of each generation (Bulzalka, 2005).

In a CCRC, the foodservice operation serves individuals who live in independent living, assisted living, and healthcare. To generate profit in the foodservice operations, the primary focus is on independent living. A study completed by Cluskey (2001) found that 73% of the residents in independent living eat most of their meals in the collective dining room, but did not specify how often they ate in the dining room. The study also found that that only 17% of the residents dine out one or more times per week (Cluskey, 2001). In the Restaurant &Institution's New American Diner Study, individuals over the age of 61 were more likely to dine away from home more frequently than any other population sector. More than one third of the participants stated the reason for dining out more frequently was for social interaction with family and friends (Leahy, 2007).

In the past 20 years, the CCRC environment has changed from a health care model to a hospitality model (Jones, 2009). Along with this change, wellness is now being added to the model (Buzalka, 2005). One of the main focal points for this wellness approach is to combine healthy meals with a fine dining experience (Buzalka, 2005). According to Sheridan (2002) who wrote the article "Inviting Options", foodservice managers, in order to be successful, must drop the misconception of how they perceive aging. The goal should be to change the type of

foodservice operation at CCRCs to one that can function within the market in the greater community. Most foodservice operations within CCRCs are not profit generating. Even though foodservice is not viewed as a profit center within CCRCs, it is commonly used as a marketing tool to influence potential clients. Thus, many CCRCs across the United States are employing individuals who have experience in the hotel/restaurant industry (Cavanaugh, 2003). In a study conducted by Lee et al. (2003) in CCRCs, the participants rated quality of foods, trained chef on staff, consistency of food, and availability of the food as attributes of excellent foodservice. Along with food quality, the trend is moving towards global flavors and serving healthy foods (Anonymous, 2008). Howells (2007) and Seo and Shanklin (2005) found residents who live in independent living and assisted living at CCRCs rated service quality higher than food quality. This concept is changing the way CCRC foodservice operations are managed across the United States. As staff turnovers occur, the trend is to select employees with culinary training or restaurant experience as replacements (Lawn, 1996; Lutz, 2001).

Many CCRCs are transforming their formal dining room into different venues. Some examples are bistros, exhibition-style cooking, bakery shops, tea room, full bar and lounge areas, private dining rooms, and convenience stores (Anonymous, 2009; Buzalka, 2005; Friedland, 2000; Watkins, 1998; Lawn, 1996). As the aging population increases, there is demand for greater selections, more menu items, and vegetarian choices along with expanded hours (Buzalka, 2005; Freidland, 2000; Jones, 2009).

Within CCRCs, residents dine in the same restaurant daily, making it difficult to maintain customer satisfaction (Lawn, 1996; Northern Service Group, 2007). This is why the hospitality service and type of staffing continues to play a role in the success of the CCRC dining service. Customer satisfaction in CCRCs must be focused on service marketing which includes tangibles,

reliability, responsiveness, assurance, and empathy in all departments (Dube, Renaghan, and Miller, 1994; Northern Service Group, 2007). Attributes that pertain to food quality are food taste and food consistency. Attributes for service quality in CCRCs and restaurants include attentiveness, menu variety, helpfulness of staff, wait time to be seated, and atmosphere (Dube et al., 1994; Howells, 2007; Aramark, 2008).

As this trend continues toward hospitality services, there is a change in the CCRC foodservice operation leadership. Individuals and family members expect good quality service (Northern Service Group, 2007). Therefore, CCRCs are employing managers who have culinary backgrounds to increase overall customer satisfaction, quality of food, and quality of service. There is minimal research to determine if replacing foodservice managers with individuals with culinary experience improves overall customer satisfaction, quality of food, or quality of service. For the purpose of this study, culinary experience is defined as formal education in a culinary arts program or work experience using culinary skills in a hospitality setting.

The purpose of the study was to assess residents' overall satisfaction with quality of food and quality of service in Continuing Care Retirement Communities (CCRC) and retirement communities when the facility employs a foodservice director or chef with culinary training or expertise. The objectives of this study were as follows:

1.) Determine the level of overall satisfaction with the quality of food and services provided by foodservice.

2.) Determine if providing different dining venues increases overall satisfaction.

3.) Explore the effect of requiring a meal plan on customer satisfaction and frequency of dining.

4.) Explore if the frequency of interaction with the chef or foodservice manager influences customer satisfaction.

5.) Assess if demographic characteristics such as sex, generations, marital status, and length of stay effect overall customer satisfaction.

The research questions addressed by this study are as follows:

1.) Has administration noticed a change in overall customer and staff satisfaction in the restaurant/dining room since employing someone who has culinary experience?

2.) What is the residents' satisfaction with food and service quality?

3.) Does having a required meal plan influence overall customer satisfaction?

4.) Does the frequency of interaction of residents with the chef or foodservice manager influence overall customer satisfaction?

5.) Does the demographic characteristic of residents which, includes sex, marital status, and length of stay at the facilities, influence overall customer satisfaction?

Definitions

Aging: Length of life or existence in time which changes of mental, physical, and emotional development of a person occurs (AAHSA, 2008).

Aging in Place: Maintaining independence with dignity in a safe and comfortable environment (Senior Resource Alliance, 2008).

Continued Care Retirement Community: A living arrangement that enables residents to continue to live in a planned community. There are three primary living options including independent housing, assisted living, and healthcare (Senior Resource Alliance, 2008).

Retirement Community: Provides service for independent living only, but many of the services offered in Retirement Communities are the same as in Continued Care Retirement Communities (AAHSA, 2010)

Meal Plan: A plan that sets aside money in a resident's account which is automatically billed each month for the use of goods in a continued care retirement community or retirement community.

Culinary Experience: For the purpose of this study, culinary experience is defined as formal education in a culinary arts program or work experience using culinary skills in a hospitality setting.

GI Generation: Born between 1901-1924. This generation is characterized by feeling they are the best generation and abide by the will of the community (Friedland, 2000).

Silent Generation: Born between 1925-1942. This generation is characterized by being value conscience and involved in decisions that affect them as individuals (Friedland, 2000)

Baby Boomers: Born between 1946-1964. This generation is characterized by wanting to be involved in decisions and choices that impact their lives. This generation has traveled more and will demand higher food quality and a variety of flavors and menu items (Buzalka, 2005).

References

American association of homes and security for the aging (AAHSA). (2008). Retrieved from http://www.aahsa.gov

American association of homes and security for the aging (AAHSA). (2010). Retrieved from http://www.aahsa.gov

Anonymous. (2008). Menu trends. *FoodService Director,* 21(4), 12-2.

Anonymous. (Dec 2009). Lap of Luxury. *Long-Term Living*. 58 (12), 19-22.

Administration on Aging. (2009). *A profile of older Americans: 2009.* Retrieved from http://www.aoa.gov

Aramark. (2008). *What seniors think about CCRCs: What's important to your residents and prospective residents.* Retrieved from http://www.aramark.com

Baker, H. (2007). Nutrition in the elderly: Diet pitfalls and nutrition advice. *Geriatrics,* 62(10), 24.

Briley, M. E. (1994). Food preferences of the elderly. *Nutrition Reviews,* 52(8), S21.

Brandon, B., & Flury, E. (Jan 2009). Aging with choice: Coping with a changing marketplace. *Long-Term Living*. 58 (1), 15-18.

Buzalka, M. (2005). What does the future hold for CCRCs? *Food Management,* 40(9), 40.

Cavanaugh, B. B. (2003). Upscale dining drives sales at Hyatt Retirement Village-news-Hyatt at the glen. *Nation's Restaurant News*

Cluskey, M. (2001). Offering three-meal options in continuing care retirement communities may improve food intake of residents. *Journal of Nutrition for the Elderly,* 20(3), 57-62.

Dube, L., Renaghan, L. M., & Miller, J. M. (Feb 1994). Measuring customer satisfaction for strategic management. *Cornell Hotel and Restaurant Administration Quarterly,* 35(1), 39-48.

Fox, T., Brummit, P. S., Ferguson-Wolf, M., Abernethy, M., & et al. (2000, May). Position of the american dietetic association: Nutrition, aging, and the continuum of care. *Journal of American Dietetic Association,* 100(5), 580.

Friedland, A. (2000, November). Senior dining, A revolution in the making? *Food Management,* 35(11), 44-48.

Groger, L., & Kinney, J. (2006). CCRC here we come! reasons for moving to a continuing care retirement community. *Journal of Housing for the Elderly, 20*(4), 79.

Howells, A. (2007). The impact of perceived quality on assisted living residents' satisfaction with their dining experience. Unpublished master dissertation, Kansas State University, Kansas.

International Food Information Council. (2001). Exploring the food and health attitudes of older Americans. *Journal of Nutrition for the Elderly,* 20(3), 39-44.

Jang, S., Ham, S., & Hong, G. (May 2007). Food away from home expenditure of senior households in the united states: A double hurdle approach. *Journal of Hospitality and Tourism Research,* 31(2), 147.

Jhaveri, T.S. (2006). Enhancing the dining experience in senior living. *Nursing Homes,* 55(10), 56.

Jones, Alicia (Dec 2009). Living the boutique lifestyle. *Long-Term living*, 58 (12), 25-27.

King, P. (Dec 1999). Aging boom propels specialization trend. *Nation's Restaurant News.* 33 (50), 75-77.

Kellogg, K. (Jan 2009). 10 tips for choosing a retirement home. *VFW, Veterans of Foreign Wars Magazine.* 96 (5), 46-48.

Kim, T., & Almanza, B. A. (2001). Three nutrition labeling formats for restaurant menus: Retirement community residents' response. *Journal of Nutrition in Recipe and Menu Development,* 3(2), 45-57.

Lawn, J. (1996, November). A retirement community transition. *Food Management,* pg. 40-48.

Leahy, K. (April 2007). Mature Choices. *Restaurant and Institutions.* 117 (6), 61.

Lee, K., Shanklin, C. W., & Johnson, D. E. (2003). Development of service quality measurement for foodservice in continuing care retirement communities. *Foodservice Research International*, pg. 1-21.

Lutz, B. (June 2001). A restaurateur's approach. *Contemporary Long Term Care,* pg. 15.

Northern Services Group Inc. (2007). Northern hospitality: Creating a hospitality culture in a nursing home setting. pg. 26-35.

Senior resource alliance. (2008). Retrieved from http://www.seniorresourcealliance.org/

Seo, S., & Shanklin, C. W. (2005). Important food and service quality attributes of dining service in continuing care retirement communities. *Journal of Foodservice Business Research,* 8(4), 69-86

Sheridan, M. (2002). Inviting options. *Restaurants and Institutions,* 112(21), 97.

Watkins, C. (1998, June). New bistro at CCRC increases customer satisfaction, provides competitive advantage. *Food Management,* 33(6), 20.

CHAPTER 2 - Review of Literature

Elder Population in the United States

Current Profiles

The number of Americans over the age of 65 was approximately 38.9 million as of 2008, representing 1 in 8 Americans. The population over the age of 65 is predicted to increase to 72.1 million by 2030 or 19.3% of the population (Administration on Aging [AOA], 2009). Aging is defined as the length of life or existence in time in which changes of mental, physical, and emotional development of a person occurs (Administration on Aging [AOA], 2007). Holmes (2006) defined aging as the changes that occur over a lifespan as it relates to the physical, psychological, and social changes. Diverse life experiences and genetic traits impact the rate at which an individual ages (Fox, Brummit, Ferguson-Wolf, Abernethy et al., 2000). As researchers investigate the demographics of aging, greater emphasis has been placed on age-related vulnerability to disease (geriatrics) rather than normal aging, referred to as gerontology (Hetherington, 1998). However, there is a need to investigate variables related to normal aging as they relate to the quality of life of older adults.

As the number of Americans over age 65 increases, more individuals with high mortality risks are living longer than in the past (Parker and Thorslund, 2007). Hetherington (1998) classified older adults 65 years of age and older into three categories: the 'young-old' individuals 65-74 years old, 'old-old individuals 75-84 years and the oldest-old individuals 85 years or older. The U.S. Census Bureau predicted as the baby boomers continues to age, the oldest-old population will rapidly grow (AOA, 2007). The demographics of individuals in these different

categories can influence the type of dining services needed and desired based on the need for assistance with activities of daily living (ADL). According to Hetherington (1998), only 6% of the 'young-old' reported difficulty with at least one ADL compared to 35% of those age 80-85 years old.

It is important for managers to understand the generations who will be over the age of 65 by 2020 in order to predict what is needed in the future for foodservices. The three generations that will impact products and services offered are the GI generation, Silent generation, and Baby Boomer generation (Brandon and Flury, 2009). Dolloff (as cited in Friedland, 2000) defined the generations that currently make up the generations living in Continued Care Retirement Communities (CCRCs) and retirement communities as the following. 1.) Individuals who were born 1901-1924 are considered the GI generation. This generation helped create the continued care retirement community in the early 1980's. These individuals characterize themselves as being the best generation and abide by the will of the community. 2.) The Silent generation born between 1925 and1942 reached the peak of their retirement in 2005. They are characterized as being value conscience and involved in decisions that affect them as individuals (Brandon and Flury, 2009; Friedland, 2000). 3.) The Baby Boomer generation, which was born between 1946 and 1964, will have the most impact on foodservices. This generation has traveled more and will demand higher food quality and a variety of flavors and menu items (Buzalka, 2005). Operations that serve this clientele will need to change and focus on how to target the aging population (Brandon and Flury, 2009).

Food and Nutrition for the Elderly

Importance of Food and Nutrition for Older population

As individual's age, nutrition and eating play important roles from both medical and social contexts (Fox et. al., 2000). As the older population continues to grow, there is emphasis to decrease frailty among the elderly to maintain low health care costs which are estimated to be 3-5 times higher for individuals over the age of 65 (Semba, Bartali, Zhou, Blaum, and Fried, 2006). Quality of life and quality of health are positively related and nutrition can play a role in maintaining both of these (Fox et al., 2000, Holmes, 2008). Poor nutritional statusresults in decreased immune function, impaired muscle function, physical strength, and increase mortality which can impact quality of life (Holmes, 2006; Carriere, Dupuy, Lacroux, Cristol, Delcourt, and Pathologies Oculaires Liees Age, 2008). The goal of organizations that provide products and services for aging Americans should be to improve the quality of life, not the length of life (Briley, 1994). In the foodservice industry, a custom array of food and nutrition services is required to meet the changes in physiological, mental, functional, and socioeconomic capabilities of the older adult population (Fox et al., 2000).

Health Issues of Aging Population

Obesity is a major epidemic occurring in the United States and obesity rates are increasing in the older population (AOA, 2007). The rate of obesity has increased 36% in the past 40 years. Currently, 73% of the older population is overweight (AOA, 2007). In the general population, this is a major health problem which can impact the functional and

psychosocial areas of an individual's life as they age. Obesity also increases the risk of coronary artery disease, type 2 diabetes, and cancers (AOA, 2007).

Along with the concern about obesity, studies have shown that after the age of 50, loss of muscle mass occurs which can cause a decline in body weight (Fox et. al., 2000; Hetherington 1998). Hetherington (1998) indicated that adults lose an estimated 3 kg of lean body mass per decade. Some of the main reasons for this are related to changes in the ability to control food intake and multiple lifestyle changes which include becoming sedentary, reduction in food intake, decrease in resting energy metabolism, onset of illness, and use of appetite-suppressant medication (Hetherington, 1998, Drewnowski and Shultz, 2001; Roberts, Fuss, Heyman, Evans, Tsay, Rasmussen et al., 1994). These lifestyle changes can cause weakness, fatigue, increased mortality, and functional decline, which impacts the goal of maintaining a quality of life (Holmes, 2006; Locher, Ritchie, Robinson, Roth and Delia, 2008). Several studies have shown underweight status and unintentional significant weight loss decreases life expectancy in individuals 60 years or older (Hetherington 1998; Fox et al, 2000; Drewnowski and Shultz, 2001; Locher et al, 2008). It is estimated that 3% of older men and 6% of older women living in CCRCs are considered underweight and the percentages increase as individuals move into long term care facilities. Maintaining the desire to eat and the enjoyment of food has been shown to minimize the risk of weight loss and under nutrition (Fox et al., 2000).

With changes in lifestyle as we age, there continues to be a reduction in the amount of energy consumed (Hetherington, 1998; Drewnowski and Shultz, 2001; McCary, 2008). Lower energy intake was associated with consumption of smaller meals eaten at a slower rate in older adults compared to younger adults (Hetherington, 1998). According to the Continuing Survey of Food Intakes for Individuals conducted by the USDA, the elderly eat two to three meals per day

(Cluskey, 2001). Regardless of the number of meals consumed, individuals 70 years or older eat more fruit and dairy than younger people, but the same or slightly less of grain, vegetable, and meat (Drewnowski and Shultz, 2001). Decreased consumption of grain, vegetable, and meat is correlated to chewing difficulties (Cluskey, 2001; McCary, 2008). A New Mexico Aging Process Study found a decrease in consumption of total energy from meat, fish, and poultry in the older population (Koehler, 1994). A Ross study which investigated meal consumptions in the older population found that 20-30% of individuals 65 years or older skipped lunch and 30 to 40% consumed snacks (Houston, 1994). Semba et al. (2006) reported that women who did not consume enough nutrients were at higher risk of decreased quality of life. This decrease in consumption of nutrients can be related to difficulty shopping, meal preparation, and aging (Semba et al., 2006).

The specific dietary recommendations for essential nutrients in older adults have not been fully studied (Fox et al., 2000). Older adults have specialized requirements for a variety of nutrients because aging effects absorption, utilization, and excretion (Fox et al., 2000; Drewnowski and Shultz, 2001). Evidence supports that the nutrient needs for adults between 60-79 years and adults greater than 80 years of age are not the same (Fox et al., 2000).

Aging Characteristics and Their Impacts on Food Intake

Physiological Factors

As we age, adults experience a decline in their ability to respond to changes in either the internal or external environment (Hetherington, 1998). The decline can be related to the slowing of the mechanisms and stimuli that affect food intake (Carriere et al., 2008; Holmes, 2008). The physiological and functional changes of aging result in changes in nutrient needs (Fox et al.,

2000). Genetics also can influence the physiological changes that individual experience as they age (De Castro, 2002). Some of the physiological factors that impact the older population's food intake are homeostasis, sensory loss, and appetite regulation.

The rate of homeostasis is delayed with aging, which can be related to the increase risk for dehydration as people age. For an older adult, the individual may not recognize they are dehydrated and fail to get re-hydrated. Dehydration is a very common problem in older adults and can affect taste perception and appetite regulation and is responsible for 6.7% of hospitalizations in older adults (Fox et al., 2000; Hetherington, 1998). If an individual does not maintain proper hydration, constipation, fecal impaction, cognitive impairment, functional decline, and death can result (Fox et. al., 2000).

Sensory loss, which includes taste, smell, and vision, has a major impact on an individual's food consumption (Holmes, 2008; Holmes 2006; McCary, 2008; Hetherington, 1998). Fifty percent of the older population over the age of 65 years experience problems with taste and smell and this loss increases to 75% for individuals over the age of 80 (McCary, 2008).

The five basic tastes that individual's experience are salty, sweet, sour, bitter, and unami (Mojet, Christ-Hazelhof, and Heidema, 2001). In older adults, there is a decrease in preference for sour, bitter, and pungent tastes and a decrease in smell (Hetherington, 1998). The primary taste that is affected when we age is salty. Older adults experience a decrease in sensitivity which is why many individuals add more salt to their food (Mojet et al., 2001; McCary, 2008). Studies show that men are more prone to sensory loss than women (Mojet et al., 2001). Medications can affect taste perceptions and the number of prescriptions filled for the elderly increased from 18% in 1992 to 30% in 2000 (AOA, 2007; Holmes, 2006). This increase in medication can have a major impact on the loss of flavor in food for the older population,

sometimes leading to anorexia (Holmes, 2006; Holmes, 2008). Impaired vision can change the lifestyle of individuals in a range of areas which includes social domains, communication, mobility, and psychosocial (Othelia and Brennan, 2006) and can affect both the social engagement at meal times and the amount consumed (Brennan, 2003).

Flavor is rated highly important in determining food choice in the elderly. Both taste and smell affect flavor perception. Smell is the second sensory loss that is affected as individual's age (Baker, 2007; Hetherington, 1998). More than 50% of individuals between the ages of 60-80 years have smell impairments (Drewnowski and Shultz, 2001). As one's ability to smell decreases, a decreased interest in food occurs. Higher intake of sweet foods and a decreased preference for sour, bitter, and pungent taste occurs when the sense of smell decreases (Duff, Backstrand and Ferris, 1995). Baker (2007) indicated that when the flavor of the food has been enhanced, individuals will be more likely to consume the food.

Appetite regulation changes as individuals age (Holmes, 2006). The physiological mechanism that affects appetite regulation is the gastric system emptying of solids and liquids. This mechanism is slower in the elderly (Hetherington, 1998; Drewnowski and Shultz, 2001; Holmes, 2008). Appetite changes often occur after an individual has experienced an illness or has experienced chronic health problems (Holmes, 2006). Roberts et al. (1994) reported that individuals who were underfed or overfed were not able to return to their normal weight which is caused by decrease in the mechanism that controls food intake and regulates energy intake in the body (Roberts et al., 1994; Holmes, 2008). The loss of taste and appetite regulation often leads to anorexia of aging which decreases the amount of muscle mass in individuals and increases the risk of frailty (Carriere et al., 2006).

Psychological Factors (Gender, Living Situation, and Finances)

Non-physiological factors can impact food intake in the older population. The three main areas of focus in this section are social, psychological, and environmental factors as they relate to food consumption.

Meals can be a time for socialization and getting to know people. Older individuals report that being part of a strong social network makes them feel healthier and happier (Capel, Childs, Banwell, and Heideman, 2007). As individuals age, the number of people they know often decreases, impacting individual food intake because of less social interaction (De Castro, 2002; Baker, 2007). Eating is an important psychosocial activity (Briley, 1994; Holmes, 2008). In the older population it can be difficult to shop and prepare meals resulting in skipped meals or inadequate nutrient consumption (Holmes, 2008; McCarey, 2008). Locher et al. (2008) found that 70% of homebound older adults did not consume enough calories to maintain current body weight. De Castro and De Castro (1989) reported that meals eaten with other people are on average 46% larger than meals eaten alone. There are positive nutritional benefits for individuals who have a social network and support systems (Locher et al., 2008). Women tend to eat more when men are present and both men and women eat more when in the presence of family and friends (Holmes, 2006). A decrease in dietary intake can be impacted by loneliness, especially in individuals who are widows or widowers (De Castro, 1994; Donini, Savina, and Cannella, 2003; Holmes, 2006; Holmes, 2008; Baker, 2007). Individuals who live together are more likely to consume a balanced diet (Briley, 1994). Depression is very common in the older population. The condition is often not recognized, but depression can have a major impact on food intake and lead to anorexia (Holmes, 2006; Locher et al., 2008).

Environmental factors play a role in the experience and meal intake for all the population. This is especially important in the older adult population. De Castro (2002) reported that when an institutionalized elderly setting for meals was changed to incorporate restaurant like qualities, eating behavior significantly improved and food intake increased.

De Castro (2002) found that time of day is an important factor in determining how much an individual consumed per day. As the day progresses, the meals become larger, while the time between meals becomes shorter. The problem with the timing and size of the meal is that most elderly eat earlier in the day than younger people. This causes the elderly to eat during periods of high satiety and less as the day progresses (De Castro, 2002).

The most non-physiological factor that affects food preferences is an individual's economic status, which is commonly termed as food insecurity (McCarey, 2008; Briley, 1994). The Census Bureau (2008) reported that in 2006, 9.4% of individuals over the age of 65 were below the poverty level. In a study conducted in 1999, 40% of older adults between the ages of 60-90 years will experience at least one year below the poverty level and 48% will experience poverty at 125% poverty level (Fox et al., 2000). As the older adult population increases, this demographic will continue to be a concern. As expenses increase, such as cost of medication and medical care, the older adult may select to reduce food intake or alter the type of food item purchased to have money available to purchase medication and pay for health care expenses (Fox et al., 2000; Briley, 1994). Decrease in income can impact what types of foods are purchased and the availability of refrigeration and proper cooking equipment (Baker, 2007). Some other factors that can affect the type of food consumed are lack of physical mobility to shop and prepare food and lack of transportation (Fox et al., 2000).

Future Trends

As the population of individuals over age 65 increases, there will be a higher demand for services from this segment of the population. Within these generations there is a trend toward self care and being involved in decision making from the beginning (International, 2001). Older adults are looking for ways to improve their lifestyle and are starting to focus more on the type of food they purchase and the benefits they will obtain from these purchases (International, 2001). The older population is looking for hospitality service and the ambience that can be provided in the dining room in retirement communities (Cavanaugh, 2003).

To optimize independence, productivity, and quality of life, older adults are searching for different living options (Fox et al., 2000). In past generations, it was not uncommon for older adults who needed assistance to live with their family members. Over the past two decades the United States has experienced a change in society that impacts the aging population and the options available after retirement. These changes are a decline in family size, increase in individuals not having children, increase in geographic mobility of family members, and increase in divorce rates (HOD Backgrounder, 2008). As our society continues to change and more families are working outside the home, the parents of the younger generation do not want to be a burden on their children (HOD Background, 2008). Older adults are looking for choices in living that can help maintain their independence, but they want assurance that if they become ill, they will be taken care of by their community rather than placing the burden on their children (Groger and Kinney, 2006). The goal for many older adults who live in the United States is to maintain an active lifestyle within their home as long as they are physically and mentally capable.

Continuing Care Retirement Community

Before the 1970's, the older population had primarily two choices available for living options. These two choices were to continue living independently or move into a rigid institutional environment. In the 1970's and 1980's a new culture evolved that resulted in different choices in living options for the older adult population. This new culture was the development of CCRCs (Buzalka, 2005). A CCRC is defined as a living arrangement that enables residents to continue to live in a planned community in one of three primary living options including independent housing, assisted living, and healthcare (Senior Resource Alliance, 2008). Retirement communities are defined as providing service for independent living only, but many of the services offered in retirement communities are the same as in CCRCs (AAHSA, 2010). CCRCs in the community are characterized as long term care insurance for the older population (Groger and Kinney, 2006). At this time, approximately 10% of the U.S. population chooses to live in one of approximately 2,100 CCRCs (AAHSA, 2008). The demand for CCRCs will grow substantially over the next 20 years with the projected growth of individuals over the age of 65 years. In 1986, CCRCs housed approximately 100,000 residents, and by 2005 they housed 660,000 residents (Groger and Kinney, 2006). One of the common goals among CCRCs in the U.S. is to provide choices from a spectrum of living options and medical and supportive services to accommodate those who are fully active to someone who has severe impairments (Buzalka, 2005). Services and amenities are the top focuses for residents who are researching CCRCs as potential places to live (Jones, 2009). One of the services that individuals look for in CCRCs is the quality of onsite dining facilities (Buzalka, 2005; Jhaveri, 2006). Typically, residents living at a CCRC have several dining options including preparing

food in their own home, eating in the community, or dining at their facility (Lee, Shanklin, and Johnson, 2003).

Moving to a CCRC can give a sense of security, leading to improved quality of life (Gilleard, Hyde, and Higgs, 2007). This is commonly called 'aging in place' (Fox et al., 2000). According to Senior Resource Alliance (2008), aging in place is referred to as maintaining independence with dignity in a safe and comfortable environment. As aging in place becomes more popular, this will increase the need to expand the type of services available in CCRCs to meet the needs of the older population. Meeting these needs can decrease the risk for under nutrition with the community support provided the residents (Locher et al., 2008). Gilleard et al. (2007) found that aging in place was associated with an increased feeling of attachment to the community with a sense of belonging and connectedness. The community atmosphere provided by the CCRC can help prevent apathy, depression, and appetite impairment; all of which can impact the quality of life of individuals (Baker, 2007). With the goal of providing a spectrum of services, CCRC operators need to present a high-quality experience for individuals who currently live in the CCRC and to attract younger seniors. Meeting the needs and expectations of the clientele who move into CCRCs will be important, because the residents have the option to determine if they will eat in the CCRC dining room or choose other locations (Lee et al., 2003).

As CCRCs change their systems to meet the expectations of current and potential residents, it will be important to hire individuals who understand the physiological and psychological changes that occur as an individual ages. The focus will need to change to a hospitality environment (Lawn 1996; Lutz, 2001). This will include recognizing individual needs, while maintaining the dignity and independence for each individual who lives in a CCRC or is a potential resident.

Resident Profile

Senior Living Services (SLS), which is a part of Aramark, found the average age of seniors moving to a CCRC is 78 (Aramark, 2008). In a study conducted in the Midwest, the average age of seniors living in CCRCs was 84 years. These individuals had lived at the CCRCs an average of five years (Seo and Shanklin, 2005). Most residents make the decision to move into a CCRC when they needed more medical assistance and had tried other options (Aramark, 2008). Reasons for moving into a CCRC include the ability to plan to do so, readiness, fear of burdening family, difficulty in maintaining their home and yard, spouse's failing health, and a desire to downsize (Groger and Kinney, 2006). Most CCRC operators' primary focus is to have individuals move to their CCRCs at an earlier age before they have exhausted their financial resources to other services within the community. Aramark's research SLS (2008) found that 94% of individuals living in independent living units of CCRCs are retired, 35% are widowed, the average net worth is approximately $1 million, and the average annual household income is $67,000. The majority (51%) have a two to four year degree and 31% of individuals have a master's degree or higher. In a study conducted in the Midwest, approximately 52% of the individuals completing the survey had a one year degree or higher and the average income was less than $40,000 (Seo and Shanklin, 2005). Aramark states that the residents' educational level is well above the norm when compared to the national sampling of 50-70 year olds (Aramark, 2008). The aging statistics from the government show that in 2007, 17% of the total older population had a bachelor's degree or higher (AOA, 2007). Even though there is a perception that only affluent individuals can move into a CCRC, their financial requirements are within reach for approximately 50% of the older population (Groger and Kinney 2006). Although it is financially feasible for half of the population, most individuals who move into a CCRC have a

higher education, higher income, previously lived in an owner-occupied residence, and had been employed in a white collar occupation (Martikainen, Nihtila, and Moustgaard, 2008).

Many individuals who move into a CCRC have been a member of a country club for several years and expect the same quality of food and dining as they have received at the country club (Cavanaugh, 2003). As the older population continues to expect a higher quality of a dining experience, there will be a greater demand to provide quality food with a new twist on how it is served and presented (Fox et al., 2000).

A higher percentage of females compared to males reside in independent living units of CCRCs (Falkingham and Grundy, 2006). In the current generations living in CCRCs, more women than men cook (Falkingham and Grundy, 2006; McCarey, 2008) and this can impact the foodservice operation because women better understand quality and preparation of food.

Baby boomers are more flexible about moving to a new home than generations in the past. The primary reason for this flexibility is that most have moved several times during their lifetime because of changes in jobs. This change in flexibility makes individuals feel more comfortable with moving from their home in the community into a CCRC (Aramark, 2008).

Older Population

As the population of Silent generation and Baby Boomers generation continues to grow, they want to be a part of the learning process (Briley, 1994, Friedland, 2000). The learning process will take on many forms as the number of individuals over the age of 65 increases. The demand for health information as it relates to food intake will become more prominent. As people age, there is an increase in food interest as it relates to health and the older population want to choose the food they eat (International, 2001; Friedland, 2000). Many elderly expect information relating to health or any type of information to be provided in documentary style

such as they see on television (Briley, 1994). In the general media, receiving information through documentary style is becoming less popular. Currently, there is a demand to provide television programs that increase people's knowledge of food and in turn increase their demand for higher quality food (Premier, 2007; Canter, Moorachian, and Boyce, 2007). Research has shown that the elderly population is more likely to read printed information at shelf levels or in newsletters compared to using the computer (International, 2001). In the UK, only 15% of individuals over 65 years old had internet access. In the United States, the most viewed sites by the older population were health topics (Capel et al., 2007).

The older adult population looks to food to project value (Briley, 1994), which can play an important role in where and what they eat on any given day or where they choose to live. Sometimes food is the only thing left that they are able to control which can impact their food intake (Briley, 1994)

According to Briley (1994), food selection symbolizes comfort, happiness, and pleasure. For the GI generation and Silent generation, it would not be uncommon for these generations to choose home style cooking (Bond, 1996) while the younger generations want more variety and healthy options (Buzalka, 2005). Research also has shown that as people age, they tend to go back to their childhood favorites (International, 2001).

In many CCRCs, the current age group falls between the GI generation and Silent generation. Both of these generations have their own unique personality which can impact what type of service is expected in CCRCs (Brandon and Flury, 2009; Buzalka, 2005). Food service managers will need to learn what services all three generations will expect. As each of these unique generations try to share the same community, it will place a higher demand on the foodservice to provide quality meals that meets each of the generation's needs (Bulzalka, 2005).

The elderly population puts value on food. This population expects food to look good, taste good, and smell good. As the Baby Boomer generation moves toward the older population they will demand that the food not be bland (Premier, 2007). Convenience is another value placed on food (International, 2001; Watkins, 1998). In the general population, convenience means speed, but for the older adults, it means food items that are easy to open and reclose, labels that are large type instructions that are easy to read, and small package sizes (International, 2001).

The elderly population considers a balanced meal a healthful meal (International, 2001). The beliefs surrounding these balances increase significantly when people move into a CCRC (International, 2001). Older consumers prefer foods that they know and love, especially the GI generation (Friedland, 2000). The elderly population accepts changes made to familiar food items as long as the taste remains the same (International, 2001). They also deal more readily with accepting small changes rather than one big change (International, 2001).

As residents expectations of the foodservice continue to change in CCRCs, it will be important for foodservice managers to maintain a balance of listening to what the customers desire and what they will actually consume. Many times foodservice managers expect the older population to change lifelong eating habits with established food preferences; this is not realistic for a foodservice operation in CCRCs (Holmes, 2006). In the past, nutrition has played a major role in what was served in a retirement community. Nutrition continues to be important, but individuals selecting to live in CCRC are expecting higher quality of service and increased food quality.

Concepts and Operational

The traditional dining room concept for CCRCs was developed in the early 1980's. At that time the individuals who were moving into CCRCs demanded formal dining service that included being served with gracious style. The same menus were used for all three different housing levels: independent living, assisted living and healthcare. Typically, the menu cycle was established and changed every quarter or season (Bond 1996; Riell, 2000; Lawn, 1996). The menus ranges from comfort foods to special items served two or three times per week (Riell, 2000) and the menus were developed based on the color, texture, and appearance of menu items (Riell, 2000).

The main area of focus to help generate profit in the foodservice operation is independent living. The type of service that is provided in the independent living dining room ranges from buffet style to wait staff service. Each CCRC operates under a different type of meal plan. Some of the types of meal plans are one meal per day, all meals, or no meal plan (Cluskey, 2001; Lawn, 1996). When CCRCs require a meal plan, this provides a small profit margin in foodservice compared to facilities that provide no meal plans (Cluskey, 2001). Cluskey (2001) found that 73% of the residents indicated they eat most of their meals in the collective dining room, with only 17% stating they eat out one or more times per week. This study was completed at a CCRC that had a meal plan in place (Cluskey, 2001). Some advantages to meal plans are increased profit, increased food intake, increased socialization, increased relationship and enhanced awareness if a change in health status occurred (Cluskey, 2001). When residents become more frequent users, the view point of a business transaction is gone and a personal relationship is established (Seo and Shanklin, 2005). In the Restaurant & Institutions' New American Diner Study, individuals over the age of 61 were more likely to dine away from home

more frequently than another population. In the study, more than one third of the participants stated the reason for dining out more frequently was for social interaction with family and friends (Leahy, 2007).

Concept and Operational Trends

In the past 20 years, the CCRC environment has changed from a health care model to a hospitality model and now is adding in the wellness model (Buzalka, 2005). This can provide opportunities to the foodservice industry along with CCRCs to promote preventative services while promoting a healthy lifestyle (McCary, 2008). One of the focal points for this wellness approach is to combine healthy meals with a fine dining experience (Buzalka, 2005). The older adult population has increased the expectation for quality dining and more options for socializing. This includes CCRC, assisted living, and hospital settings. In a study completed by Aramark, one of the top drivers that influenced future potential residents and current residents to move to a CCRC was the food quality (Aramark, 2008). According to Sheridan (2002) who wrote an article on "Inviting Options", in order to be successful, foodservice managers must drop the misconception of how they perceive aging to be successful. The goal should be to change the type of foodservice operation at CCRCs to one that can function within the market in the greater community. The environment at CCRCs also needs to focus on prevention rather than treatment and on how to improve quality of life for the residents so they can remain independent.

In CCRCs, foodservice operations are not profit generating. Even though administrators do not view the foodservice as a profit center, it is commonly used as a marketing tool to influence potential clients. When viewed as a marketing tool, the dining experience along with the food quality becomes even more important. Studies conducted by Howells (2007) and Seo and Shanklin (2005) found frequent users of the dining facility in CCRCs can be utilized as a

marketing tool when satisfaction is achieved from the dining experience. In the past, the goal was to provide quality dining and services within the model that has been in place since the early 1980s. This type of model is not meeting the expectations of today's residents. Thus many CCRCs across the United States are employing individuals who have experience in the hotel/restaurant industry (Cavanaugh, 2003). In a study conducted by Lee et al. (2003), the participants rated quality of foods, trained chef on staff, consistency of food and availability of the food as attributes of an excellent foodservice. Along with food quality, the trend is moving towards global flavors and healthfulness of the type of food being served (Anonymous, 2008). This expectation will help to market the retirement community as a potential place to live (Aramark, 2008; Cavanaugh, 2003). The Hyatt Retirement Village has transitioned to this model by changing management and bringing in individuals who have a hospitality background. With this change in management, Hyatt Retirement Village has seen an increase in seniors moving to their facility. Senior management attributes this to the quality dining it provides. The formal dining room was transformed into a restaurant environment (Cavanaugh, 2003). They continue to use a 5-week menu cycle, but frequently added specials to enhance the service and quality of food they provide (Cavanaugh, 2003).

The methodology and system of how operations serve and deliver the meals affects the entire dining experience (Look, 1996). A study conducted by Seo and Shanklin (2005) and Howells (2007) found that the respondents rated service quality higher than the food quality. Look (1996) stated that everyone has systems, but the people who operate the business are the ones who will determine the success of foodservices. Lawn (1996) reported that one CCRC hired a chef from the lodging industry to bring his hospitality management experience to the CCRC's foodservice operation. The goal is to bring culinary traditions and expectations to the

institutional environment and change the dining experience (Brandon and Flury, 2009; King, 1999; Lawn, 1996). This concept is changing the way foodservice operations are managed across the United States. As staff turnover occurs in CCRCs, the trend is to recommend employees with culinary training or restaurant experience be selected as replacements (Lawn, 1996; Lutz, 2001). One of the main reasons for this change is that as the baby boomers move into a CCRC, they expect a service focused culinary experience (Aramark, 2008).

CCRCs are hiring individuals with culinary experience to train the staff on specific skill sets (Look, 1996; Bond, 1996). There is also an emphasis to provide hospitality training which emphasizes the importance of the psychosocial needs of the residents (Aramark, 2008). This focus can help increase quality, team morale, and upgrade staff's sense of professionalism (Lawn, 1996; Bond, 1996).

There is a tug of war between the GI generation and the Silent generation on what needs to be provided in the dining service. According to Buzalka (2005), there continues to be a demand for comfort foods choices for the older generations while the younger generations are pushing for ethnic cooking. Many CCRCs are transforming their formal dining room into several different venues. Some examples are bistros, exhibition-style cooking, bakery shops, tea rooms, full bar and lounge areas, private dining rooms, and convenience stores (Anonymous, 2009; Jones, 2009; Buzalka, 2005; Friedland, 2000; Watkins, 1998; Lawn, 1996). As the aging population increases, there is demand for greater selections, more menu items, and vegetarian choices along with expanded hours (Buzalka, 2005; Freidland, 2000). People want the option to select healthy menu items from the menu, but they may not always choose it (Friedland, 2000). This change in expectation is making the foodservice operation in CCRCs move towards ala carte menus and expanded hours and move away from set meal plans (Buzalka, 2005). When

choosing a retirement community, approximately 50% of current and future potential residents rated healthy dining options, including fat free menu options and freshness, as important choices (Aramark, 2008; Jones, 2009).

As CCRC management continue to recruit individuals with culinary experience to manage their foodservice, it is also important to find a balance between quality food and wellness. The American Dietetic Association has recognized this trend and has focused on changing the education of future dietetic students to understand both the nutrition context and culinary side (Canter et al., 2007). The American Dietetic Association's position statement states "The ADA supports both the provision of comprehensive food and nutrition services and the continuation and expansion of research to identify the most effective food and nutrition interventions for older adults over the continuum of care." (Fox et al., 2000). Dietitians have both knowledge in medical nutrition therapy and foodservice management (Canter et al., 2007; Vincent, 2008). In the past medical nutrition therapy provided less emphasis on how the food looked and tasted compared to ensuring that certain nutrients were present or absent. Dietitians continue to recognize that if food does not look good or taste good, people will not eat. The dietetic education and practice have started focusing on how to make the quality of food excellent while maintaining a balance with medical nutrition therapy (Canter et al., 2007). The balance between quality food and medical nutrition therapy will be important for both the dietitians and chefs who work in CCRCs to collaborate on how they can utilize each others skills to provide a fine dining experience in the older population (Vincent, 2008).

Customer Satisfaction

Customer satisfaction is defined as the indicator of whether or not a customer will return to a foodservice operation (Dube, Reneghan, and Miller, 1994). Dube et al. (1994) stated that restaurant failures are partly a result of management's lack of strategic orientation in measuring and focusing on customer satisfaction. Within CCRCs, residents dine in the same restaurant everyday which can make it difficult to maintain customer satisfaction (Lawn, 1996; Northern Service Group, 2007). This is why the hospitality service and staffing continues to play a role in the success of the dining service. Individuals and family members expect good quality service (Northern Service Group, 2007). The three main areas that need focus to maintain satisfaction is atmosphere, service, and food (Lutz, 2001). Dube et al. (1994) stated that satisfaction data should be used for constructive action plans and improved resource planning decisions. Customer satisfaction in CCRCs must be focused toward service marketing which includes tangibles, reliability, responsiveness, assurance, and empathy in all departments (Dube et al., 1994; Northern Service Group, 2007). Seo and Shanklin (2005) conducted a study in CCRC's to determine the difference in intentions between the frequent and occasional users of the dining room. The study found that the frequent users were more apt to continue to return if they were satisfied with their food. The occasional users were more willing to come back to the dining room again if the overall service quality was good along with communication and satisfaction of food (Seo and Shanklin, 2005). Vincent (2008) recommended that personal choice in menu options, variety of foods served and perception of good foodservice quality increased the chance residents would eat the meals at lunch time.

This change from healthcare model to a hospitality model will modify how foodservice operations benchmark services in the future. The benchmark will be based on the hospitality

industry and less on the long term care standards (Aramark, 2008). Along with the change to a hospitality focus, another benchmark for foodservice operations will be for the staff to maintain long term relationships with the individuals who live at the CCRC and future residents. This long term relationship will help to build trust and commitment to the dining service operations (Seo and Shanklin, 2005)

Attributes that pertain to food and service quality are food taste, food consistency, attentiveness, menu variety, helpfulness of staff, wait time to be seated, and atmosphere (Dube et al., 1994; Aramark, 2008). All attributes interact with each other. To consistently achieve positive satisfaction with these attributes foodservice operations will need to change recipes and preparation method (Cluskey, 2001; Bond, 1996; Friedland, 2000). Seo and Shanklin (2005) found the two most important attributes affecting food quality were flavor/taste and texture/tenderness of meats. The study also found that the two highest service quality attributes were appearance of staff and attentive service.

As the foodservice industry continues to see an increase in expectation for the type of services provided at CCRCs, the industry will be required to increase the quality of the food served (Premier, 2007; Friedland, 2000). The expectation for higher quality food is coming from people who are moving to CCRCs; these individuals have more experience with food and traveling than in the past and thus are more demanding of the foodservice in CCRCs (Friedland, 2000). There is also more demand for a higher quality of food that can help prevent under nutrition and in turn impact the resident's quality of life (McCary, 2008).

Customer service, systems, and food quality play important roles in how successful a foodservice operation in a CCRC will be. Up to this point, many foodservice operations were built around the institutional model and are typically operated by someone who had food

experience, but no background in the restaurant industry. Individuals with expertise in customer relations with restaurant experience and knowledge of quality and systems can significantly improve perceived and actual quality of the dining experience in CCRCs. Chef Campbell, who works at Hyatt Retirement Village was quoted by Cavanaugh as stating "With the ambience of the dining room and our ability to pair people together, it becomes more than just a biological function of (feeding) people, it becomes a dining experience, even at this age" (Cavanaugh, 2003).

References

American association of homes and security for the aging (AAHSA), 2008, Retrieved from http://www.aahsa.gov

American association of homes and security for the aging (AAHSA), 2010, Retrieved from http://www.aahsa.gov

Administration on Aging (AOA). (2007). *A profile of older Americans: 2007.* Retrieved from http://www.aoa.gov

Administration on Aging (AOA). (2009). *A profile of older Americans: 2009.* Retrieved from http://www.aoa.gov

Anonymous. (Dec 2009). Lap of Luxury. *Long-Term Living*. 58 (12), 19-22.

Anonymous. (2008). Menu trends. *FoodService Director, 21*(4), 12-2.

Aramark. *What seniors think about CCRCs: What's important to your residents and prospective residents*, (2008), retrieved from http://www.aramark.com.

Baker, H. (2007). Nutrition in the elderly: Diet Pitfalls and nutrition advice. *Geriatrics*, 62(10), 24.

Bond, M. (1996, August). How retirement home built 90% satisfaction: A makeover at the meadows. *FoodService Director*, 40.

Brandon, B., & Flury, E. (Jan 2009). Aging with choice: Coping with a changing marketplace. *Long-Term Living*. 58 (1), 15-18.

Brennan, M. (2003). Impaired of both vision and hearing among older adults: Prevalence and impact on quality of life. *Generations*. 27(1), 52.

Briley, M. E. (1994). Food preferences of the elderly. *Nutrition Reviews,* 52(8), S21.

Buzalka, M. (2005). What does the future hold for CCRCs? *Food Management, 40*(9), 40.

Canter, D. D., Moorachian, M. E., & Boyce, J. (2007). The growing importance of food and culinary knowledge and skills in dietetics practice. *Topics in Clinical Nutrition,* 22(4), 313-322.

Capel, S., Childs, S., Banwell, L., & Heidema, J. (2007). Access to information and support for health: Some potential issues and solutions for an ageing population. *Health Informatics Journal,* 13(4), 243.

Carriere, I., Dupuy, A., Lacroux, A., Cristol, J., Delcourt, C., & the Pathologies Oculaires Liees, A L Age. (2008). Biomarkers of inflammation and malnutrition associated with early death in health elderly people. *J Am Geratr Soc,* 56, 840.

Cavanaugh, B. B. (2003). Upscale dining drives sales at Hyatt Retirement Village-news-Hyatt at the glen. *Nation's Restaurant News,*

Census Bureau. (2008). *Census bureau estimates number of adults, older people and school age children in states.* Retrieved from http://www.census.gov

Cluskey, M. (2001). Offering three-meal options in continuing care retirement communities may improve food intake of residents. *Journal of Nutrition for the Elderly,* 20(3), 57-62.

De Castro, J. M., & de Castro, E. S. (1989). Spontaneous meal patterns in humans: Influence of the presence of the other people. *Am J Clin Nutr.,* 50, 237-247.

De Castro, J. M. (1994). Family and friends produce greater social facilitation of food intake than other companions. *Physiol Behav,* 56, 445-455.

De Castro, J. M. (2002, June). Age-related changes in the social psychological and temporal influences on food intake in free-living healthy, adult humans. *The Journals of Gerontology,* 57A(6), M368.

Doninni, L.M., Savina, S., Cannella, C. (2003). Eating habits and appetite control in the elderly: The anorexia of aging. *International Psychogeriatrics*, 15(1), 73-87.

Drewnowski, A., & Shultz, J. M. (2001). Impact of aging on eating behaviors, food choices, nutrition and health status. *J Nutr Health Aging, 5*(2), 75-79.

Dube, L., Renaghan, L. M., & Miller, J. M. (Feb 1994). Measuring customer satisfaction for strategic management. *Cornell Hotel and Restaurant Administration Quarterly, 35*(1), 39-48.

Duff, V. B., Backstrand, J. R., & Ferris, A. M. (1995). Olfactory dysfunction and related nutrition risk in free living elderly women. *Journal of American Dietetic Association,* 95, 879-884.

Falkingham, J., & Grundy, E. (2006). Healthy, wealthy and old. *Nursing Older People,* 18(9), 12.

Fox, T., Brummit, P. S., Ferguson-Wolf, M., Abernethy, M., & et al. (2000, May). Position of the American Dietetic Association: Nutrition, aging, and the continuum of care. *Journal of American Dietetic Association,* 100(5), 580.

Friedland, A. (2000, November). Senior dining, A revolution in the making?. *Food Management,* 35(11), 44-48.

Gilleard, C., Hyde, M., & Higgs, P. (2007). The impact of age, place, aging in place and attachment to place on the well-being of the over 50s in England. *Research on Aging,* 29(6), 590.

Groger, L., & Kinney, J. (2006). CCRC here we come! Reasons for moving to a continuing care retirement community. *Journal of Housing for the Elderly,* 20(4), 79.

Hetherington, M. M. (1998). Taste and appetite regulation in the elderly. *Proceedings of the Nutrition Society,* 57, 625-631.

HOD backgrounder: The changing U.S. family and the practice of dietetics. (2008). *American Dietetics Association.* Retrieved from http://www.kda.com

Holmes, S. (2006). Barriers to effective nutritional care for older adults. *Nursing Standard, 21*(3)

Holmes, S. (2008). Nutrition and eating difficulties in hospitalized older adults. *Nursing Standard,* 22(26), 47.

Howells, A. (2007). The impact of perceived quality on assisted living residents' satisfaction with their dining experience. Unpublished master dissertation, Kansas State University, Kansas.

Houston, J. D. (1994). Individual foods and food group patterns of the oldest old. *Journal of Nutrition for the Elderly,* 13(4), 5-23.

International Food Information Council. (2001). Exploring the food and health attitudes of older Americans. *Journal of Nutrition for the Elderly,* 20(3), 39-44.

Jhaveri, T.S. (2006). Enhancing the dining experience in senior living. *Nursing Homes,* 55(10), 56.

Jones, Alicia (Dec 2009). Living the boutique lifestyle. *Long-Term living*, 58 (12), 25-27.

King, P. (Dec 1999). Aging boom propels specialization trend. *Nation's Restaurant News.* 33 (50), 75-77.

Koehler (1994). The new mexico aging process study. *Nutrition Review*, 42(8).

Lawn, J. (1996, November). A retirement community in transition. *Food Management,* 40-48.

Leahy, K. (April 2007). Mature Choices. *Restaurant and Institutions.* 117 (6), 61.

Lee, K., Shanklin, C. W., & Johnson, D. E. (2003). Development of service quality measurement for foodservice in continuing care retirement communities. *Foodservice Research International,* 1-21.

Locher, J. L., Ritchie, C. S., Robinson, C. O., Roth, D. L., & Delia. (2008). A multidimensional approach to understanding under-eating in homebound older adults: The importance of social factors. *The Gerontologist,* 48(2), 223.

Look, D. (1996, November). Exclusive FSD interview: 'rhythms of dialing dining' zeroes in on LTC feeding. *FoodService Management,*

Lutz, B. (June 2001). A restaurateur's approach. *Contemporary Long Term Care.* Pg. 15.

Martikainen, P., Nihtila, E., & Moustgaard, H. (March 2008). The effects of socioeconomic status and health on transitions in living arrangements and Mortality a longitudinal analysis of elderly Finnish men and women from 1997 to 2002. *The Journal of Gerontology,* 63B(2), S99.

McCary, J. (2008). Good nutrition for the golden years. *Fitness Journal,*

Mojet, J., Christ-Hazelhof, E., & Heidema, J. (2001). Taste perception with age: Generic or specific losses in threshold snesitivity to the five basic tastes? *Chem. Senses,* 26, 845-860.

Northern Services Group Inc. (2007). Northern hospitality: Creating a hospitality culture in a nursing home setting. pg. 26-35.

Othelia, E., & Brennan, M. (2006). Stress constellations and coping styles of older adults with age-related visual impairment. *Health and Social Work,* 31(4), 289.

Parker, M. G., & Thorslund, M. (2007). Health trends in the elderly population: Getting better and getting worse. *The Gerontologist,* 47(2),150.

Premier Inc. (2007, July). Reports summarize new developments from premier inc. *Biotech Business Week,* pg. 2144.

Riell, H. (2000, May). For assisted living residents: Balanced care corp. goes back to the basics. *FoodService Director,* pg. 45.

Roberts, S. B., Fuss, P., Heyman, M. B., Evans, W. J., Tsay, R., Rasmussen, H., et al. (1994). Food intake in older men. *Journal of American Medical Association,* 272, 1601-1606.

Semba, R. D., Bartali, B., Zhou, J., Blaum, C., Ko, C., & Fried, L. P. (2006). Low serum micornutrient concentrations predict frailty among older women living in the community. *The Journals of Gerontology,* 61A(6), 594.

Senior resource alliance. (2008). Retrieved from http://www.seniorresourcealliance.org

Seo, S., & Shanklin, C. W. (2005). Important food and service quality attributes of dining service in continuing care retirement communities. *Journal of Foodservice Business Research, 8*(4), 69-86.

Sheridan, M. (2002). Inviting options. *Restaurants and Institutions,* 112(21), 97.

Vincent, E. (May 2008). Ongoing nutrition assessment, menu modification, and personal service improve food consumption in assisted living facilities. *The American Dietetic Association,* 108(5), 792.

Watkins, C. (1998, June). New bistro at CCRC increases customer satisfaction provides competitive advantage. *Food Management,* 33(6), 20.

CHAPTER 3 - Methodology

The purpose of the study was to assess residents' overall satisfaction with quality of food and quality of service in Continuing Care Retirement Communities (CCRC) and retirement communities when the facility employs a foodservice director or chef with culinary training or expertise. The research compared satisfaction based on types of dining service provided (restaurants and café/bistros); resident characteristics such as sex and length of time residing at a facility; frequency of interaction with the chef or foodservice director; and meal plan requirement.

Population and Sample

The study was conducted in the Midwest region and included CCRCs and a retirement community in Kansas, Missouri and Nebraska. A convenience sample of one retirement community and five CCRCs were selected to participate in the study. All six facilities agreeing to participate employed either a foodservice director with culinary training or had individuals who directly reported to a foodservice director with culinary training. One of the facilities is managed by a foodservice management contract company. All six facilities provided restaurant style dining service and three had an additional café/bistro dining venue. The number of independent living residents in the facilities ranged from 120 to 1300.

Instrument Development

Questionnaire Development

The questionnaire was developed based on a previous survey instrument constructed by Huang (2004). Huang's (2004) instrument requested residents to rate the quality of food, quality of service, and overall satisfaction with the foodservice in CCRCs. Permission was obtained from the researcher to modify her instrument for this study (Appendix A). A five-point Likert scale was used to measure the level of satisfaction or level of agreement with a series of statements. The constructs measured included food quality, service quality, perception of foodservice, and satisfaction. The instrument included additional attributes related to culinary aspects, dining venues, and meal plans. The variables were included to assess if these attributes had an impact or influence on overall customer satisfaction (Appendix B). The research also included an assessment of the administrator's and/or foodservice director's perception of customer satisfaction, foodservice operations, and culinary skills (Appendix C).

Pilot Test

A pilot test was conducted in a CCRC to assess the reliability and construct validity of the instrument. The CCRC had 150 independent living residents with two dining venues and required the residents to participate in a meal plan. A convenience sample of residents attending the independent living town meeting was used to pilot test the instrument. Two forms of the survey instrument with an evaluation form were distributed. Form A had a font size of 14 and Form B had a font size of 16. Forty surveys were distributed and 28 surveys were returned for a

68% response rate. Of the 27 surveys returned, 15 of the surveys were Form A and 13 of the surveys were Form B.

Data gathered from the pilot test was entered into SPSS to assess the reliability of the instrument. The Cronbach alpha output from SPSS was used to determine reliability within the measurements. Hair, Anderson, Tatham, and Black (1998) recommend the Cronbach alpha should exceed 0.70. Results revealed that the instrument was reliable with a Cronbach alpha for the instrument was 0.83. The length of time required for participants to complete the survey ranged from 15 to 20 minutes or an average of 17.5 minutes.

Table 3.1 illustrates the composite mean ratings of residents' assessment of font size, instructions easy to understand, and wording of questions easy to read. Overall the respondents did not agree or disagree that the font was easy to read and wording of questions was easy to read. As illustrated in Table 3.1, residents rated all three constructs of Form A higher than Form B. Form A, with some revisions in wording of selected items was administered.

Table 3.1-Mean Rating of Evaluation of Survey Instrument

Construct	Form A (N=13) Font Size 14		Form B (N=15) Font Size 16		Combined Form A and Form B (N=14)	
	Mean	SD	Mean	SD	Mean	SD
Instructions Easy to Read	3.54	1.61	2.80	2.11	3.14	1.89
Font Size Easy to Read	3.61	1.50	2.73	2.02	3.14	1.82
Wording of Questions Easy to Understand	3.00	1.68	2.80	2.07	2.89	1.81

Note: Rating scale was a 5 point Likert scale with 1, strongly disagree and 5, strongly agree.

The pilot instrument was reviewed to identify the specific questions that the respondents indicated were not easy to read. After review of the comments, the two open ended questions; "What do you like best about the service provided by Food Services at (name of facility)" and "What do you like best about the food served at (name of facility)" were revised since most respondents did not understand the difference. The wording of the questions was changed to clarify the difference in the two items. The difference was emphasized by bolding and capitalizing the significant words as follows; "What do you like best about the **SERVICE** provided by Food Services at (name of facility)" and "What do you like best about the **FOOD** served at (name of facility)". Several residents suggested that associate degree and an "other" category should be added to the demographic question related to the highest level of education. The instrument was modified to incorporate this change.

Administration of Survey

The administrator and/or foodservice director of the participating facilities were contacted to obtain approval to conduct research in their facility. To encourage residents to participate in the study, the researcher requested permission from the administrator and/or foodservice director to provide a short article to include in the facility's newsletter or weekly publication. The article described the purposes of the study, requested the residents to complete the questionnaire, and indicated the time, date, and location of where the questionnaire would be administered. The researcher requested permission to present information about the questionnaire to the residents. These communications occurred one week prior to the administration of the questionnaire.

The questionnaire was distributed to residents as they entered the dining room or left the dining room at lunch and/or dinner in five of the six facilities. One facility requested the

questionnaire be placed in the residents' mail boxes. The researcher was available to assist the residents with reading the instrument or marking their responses. A letter accompanied the questionnaire that discussed the purpose of the survey. The letter included the compliance information required by IRB, encouraged residents' completion of the instrument, and described the location to return the completed questionnaire (Appendix D). The completed instruments were to be placed in a sealed box that did not include any identifiers. The sealed boxes in which the residents were to return their completed surveys were placed in a convenient location close to the dining room and residents' mailboxes. The questionnaire and cover letter were printed on different colored paper to identify the facility and assure the data for each facility was accurately coded. Three days after the questionnaire was distributed, the foodservice director was asked to remove the questionnaires from the box and mail the completed questionnaire in a self-addressed postage paid envelope to the researcher.

The researcher interviewed the foodservice director and/or administrator. The researcher completed interviews with two of the six administrators and six of the foodservice directors. The interview guide used for this qualitative component of the study is in Appendix C.

Data Analysis

Descriptive statistics were used to present a profile of the respondents and the facilities. Mean ratings were computed for the following variables: food quality, service quality, atmosphere, dining venues, meal plan, and frequency. Stepwise regression and linear regression was conducted to determine significant relationship between variables and overall satisfaction. ANOVA was used to determine significant mean differences among facilities with food quality, service quality, length of stay, and overall satisfaction. T-tests were used to determine significant differences between selected variables such as gender, meal plan, education level,

length of stay, generations, dining venues, martial status, and overall satisfaction. A reliability test was conducted to assess the quality of the data. Hair, Anderson, Tatham, and Black (1998) recommends the Cronbach alpha should exceed 0.70. Results revealed that the variables within the instrument were reliable. Reliability for each of the scales was as follows: food quality (0.80), service quality (0.71), dining venues (0.75), atmosphere (0.90), and overall satisfaction (0.91).

Research Compliance

Approval to conduct the study was obtained from the Institutional Review Board (IRB) for Human Subjects at Kansas State University. The researcher completed the required online training prior to submission of the IRB application. Approval from IRB was obtained prior to any data collection.

References

Hair, J.F., Anderson, R.E., Tatham, R.L., & Black, W.C. (1998). Multivariate Data Analysis (5th ed.). New Jersey: Prentice Hall.

Huang, H. (2004). Factors affecting satisfaction and residents' utilization of foodservice in assisted living facilities. Unpublished doctoral dissertation, Kansas State University, Kansas.

CHAPTER 4 - Factors Influencing Independent Living Residents' Satisfaction with Dining Experience in Continuing Care Retirement Communities and Retirement Communities

Introduction

Aging has become a focal point for several segments of the foodservice industry with the forecasted trends. In 2008, approximately 38.9 million Americans were over the age of 65 which represented 1 in 8 Americans (Administration on Aging (AOA), 2009). The Administration on Aging (AOA) (2009) has predicted that by 2030 there will be 72.1 million or 19.3% of the population over the age of 65.

As the population of individuals over age 65 increases, there will be a higher demand for services from the foodservice segment. Compared to previous generations, today's older adults have more experience with a wider variety of foods since they have traveled more than previous generations (Friedland, 2000). Older adults are starting to focus more on the type of food they purchase and the benefits they obtain from these purchases (International, 2001). Food projects value within this population (Briley, 1994); this will play an important role in where and what they eat on any given day or even where they choose to live.

To optimize independence, productivity, and quality of life, older adults are searching for different living options (Fox, Brummit, Ferguson-Wolf, Abernethy, et al., 2000). Older adults are looking for choices in living that can help maintain their independence. They want assurance that if something happens to their own health, they will be taken care of by the community they live in instead of placing the burden on their children (Groger and Kinney, 2006). To help

provide this type of living, many older adults are looking to Continuing Care Retirement Communities (CCRC) and Retirement Communities to meet this need.

Concepts and Operational

One of the most important factors that individuals seek from CCRCs is the quality of onsite dining facilities (Buzalka, 2005; Jhaveri, 2006). Typically, residents living at a CCRC have several dining options which include preparing food in their own home, eating in the community, or dining at their facility (Lee, Shanklin, and Johnson; 2003).

To increase the demand for dining at the CCRCs, facilities across the Unites States are employing individuals who have experience in the hotel/restaurant industry to enhance food and service quality (Cavanaugh, 2003). In a study conducted by Lee et al. (2003), the participants rated quality of food, trained chef on staff, consistency of food, and availability of the food as attributes of an excellent foodservice. Attributes important to this segment that are related to food quality are food taste, food consistency, attentiveness, and menu variety (Dube, Renaghan, & Miller, 1994; Howells, 2007; Aramark, 2008). In addition to food quality, more menu options, global flavors, healthfulness including organic and vegetarian choices, and expanded hours are attributes residents desire (Anonymous, 2008; Bulzalka, 2005; Dube et al., 1994; Friedland, 2000; Aramark, 2008). Howells (2007) and Seo and Shanklin (2005) conducted studies which found that the respondents rated service quality higher than food quality. Attributes important to service are helpfulness of staff, wait time to be seated, and atmosphere (Dube et al., 1994; Howells, 2007; Aramark 2008).

With the goal of providing a spectrum of services, CCRC operators should provide a high-quality experience for individuals who currently live in the CCRC and to attract younger seniors their CCRC at an earlier age. It is important for managers to understand that the baby

boomer generation, which will be 65 by 2020, will help predict what is needed in future CCRC foodservices. In many CCRCs today, the current age groups are classified as the GI generation and Silent generation. Both of these generations have their own unique personality which can impact the type of service expected in CCRCs (Brandon and Flury, 2009; Buzalka, 2005) along with the expectations of the baby boomers.

Meeting the needs and expectations of the residents will be important to maintain customer satisfaction. Thus many CCRCs are transforming their formal dining room into several different dining venues. Some examples are bistros, exhibition-style cooking, bakery shops, tea room, full service bars and lounge areas, private dining rooms, and convenience store (Anonymous, 2009; Buzalka, 2005; Friedland, 2000; Watkins, 1998; Lawn, 1996).

Within CCRCs, residents often dine in the same restaurant daily, which can make it difficult to maintain customer satisfaction (Lawn, 1996; Northern Service Group, 2007). This is why the hospitality service and type of staffing continues to play a role in the success of the CCRC dining service. Customer satisfaction in CCRCs must be focused on service marketing which includes tangibles, reliability, responsiveness, assurance, and empathy in all departments (Dube et al., 1994; Northern Service Group, 2007).

As the trend continues toward hospitality services, there is a change in the CCRC foodservice operation leadership. The trend is for CCRCs to hire managers who have culinary background with the goal of increasing overall customer satisfaction, quality of food, and quality of service. There is minimal research to determine if employing individuals with culinary experience improves overall customer satisfaction, quality of food, or quality of service. For the purpose of this study, culinary experience is defined as formal education in a culinary arts program or work experience using culinary skills in a hospitality setting.

Purpose and Objectives

The purpose of the study was to assess residents' overall satisfaction with quality of food and quality of service in Continuing Care Retirement Communities (CCRC) and retirement communities when the facility employs a foodservice director or chef with culinary training or expertise. The objectives of this study are as follows:

1.) Determine the level of overall satisfaction with the quality of food and services provided by the foodservice.

2.) Determine if providing different dining venues increases overall satisfaction.

3.) Explore the effect of requiring a meal plan on customer satisfaction and frequency of dining.

4.) Explore if the frequency of interaction with the chef or foodservice director influences customer satisfaction.

5.) Assess if demographic characteristics such as sex, generations, marital status, and length of stay affect overall customer satisfaction.

Methodology

Both qualitative and quantitative methods were used to obtain data to address the objectives and research questions. Survey data was collected from residents of independent living units in five CCRCs and one retirement community in the Midwest region to assess quality of food, quality of service, and overall satisfaction. The foodservice director and/or administrator were interviewed to obtain qualitative data.

Population and Sample

The study was conducted in the Midwest region and included retirement communities and CCRCs in Kansas, Missouri, and Nebraska. Within these three states a convenience sample of one retirement community and five CCRCs was utilized. All six facilities agreeing to participate employed either a foodservice director with culinary training or had individuals with culinary training who directly reported to the foodservice director. One of the facilities is managed by a foodservice management contract company. All six facilities provide restaurant style dining service and three had an additional café/bistro dining venue. All six facilities provided a meal plan package. At the time of the initial contact with the foodservice director prior to development of survey tool only three facilities were noted to have a meal plan package. The average number of residents who lived in the six facilities was 431 with two of the facilities having more than 700 residents. The smallest facility had 120 independent living residents. The sample included a convenience sample of all independent living residents in the CCRCs and all residents of the retirement community.

Questionnaire Development

The questionnaire was developed based on a previous survey instrument constructed by Huang (2004). Huang's (2004) instrument requested residents to rate the quality of food, quality of service, and overall satisfaction with the foodservice in continuing care retirement communities. Permission was obtained from the researcher to modify the instrument for this study (Appendix A). A five-point Likert scale was used to measure level of satisfaction or level of agreement with a series of statements. The constructs measured were food quality, quality of service, perception of foodservice, and satisfaction (Appendix B). The questionnaire included additional attributes related to culinary aspects, new dining venues, and meal plans. The

additional research questions determined if these attributes had an impact or influence on overall customer satisfaction (Appendix C).

In addition to the residents' questionnaire, the researcher interviewed the administrator in two CCRCs and the six foodservice directors to determine perception of overall customer satisfaction, foodservice operations, and culinary skills from leadership level. An interview guide with questions was developed to obtain more in depth information that could provide the researcher insight into factors that influenced residents' ratings (Appendix D).

Approval to conduct the study was obtained from the Institutional Review Board (IRB) for Human Subjects at Kansas State University. The researcher completed the required online training prior to submission of the IRB application. Approval from IRB was obtained prior to any data collection.

Pilot Test

A pilot test was conducted in a CCRC to assess the reliability and validity of the instrument. Two forms of the survey were distributed at a town meeting to the independent living residents along with an evaluation form for the actual survey. Form A (20) had a font size of 14 and Form B (20) had a font size of 16. Forty surveys were distributed and 27 surveys were returned for a 67.5% response rate. Of the 27 surveys returned, 13 of the surveys were Form A and 14 of the surveys were Form B.

Data gathered from the pilot test was entered into SPSS Windows to assess the reliability of the instrument. The Cronbach alpha output from SPSS was used to determine reliability within the measurements. Hair, Anderson, Tatham, and Black (1998) recommended the Cronbach alpha should exceed 0.70. Results revealed that the instrument was reliable with a

Cronbach alpha of 0.83. The length of time required for participants to complete the survey ranged between 15-20 minutes or an average of 17.5 minutes.

Table 4.1 presents the mean ratings for the three questions asked about to the survey instrument. The mean rating for whether the wording of the survey was easy to read indicated that participants neither agreed nor disagreed. The written comments on the pilot instrument were reviewed to identify the specific questions that were not easy to read. The two questions that the residents found confusing were the open ended questions related to "What do you like best about the service provided by Food Services at (name of facility)" and "What do you like best about the food served at (name of facility)". The residents indicated these items were too similar and most did not understand the difference. The questions were changed to distinguish the difference between the two questions by bolding and capitalizing the significant words that differentiated the two questions; "What do you like best about the **SERVICE** provided by Food Services at (name of facility)" and "What do you like best about the **FOOD** served at (name of facility)". Several residents suggested that associate degree and an "other" category should be added to the demographic question related to the highest level of education. The instrument was modified to incorporate this change.

Table 4.1-Mean Rating of Evaluation of Survey Instrument

Construct	Form A (N=13) Font Size 14		Form B (N=15) Font Size 16		Combined Form A and Form B (N=14)	
	Mean	SD	Mean	SD	Mean	SD
Instructions Easy to Read	3.54	1.61	2.80	2.11	3.14	1.89
Font Size Easy to Read	3.61	1.50	2.73	2.02	3.14	1.82
Wording of Questions Easy to Read	3.00	1.68	2.80	2.07	2.89	1.81

Note: Rating scale was a 5 point Likert scale with 1, strongly disagree and 5, strongly agree.

Administration of Survey

The administrators and/or foodservice directors for CCRCs and retirement communities were contacted to obtain approval to conduct research in their facility. To encourage residents to complete the questionnaire, the researcher requested permission from the administrator and/or foodservice director to provide a short article to include in the facility's newsletter or weekly publication. The article described the purpose of the study, requested residents to complete the questionnaire, and indicated the time, date, and location the questionnaire was to be administered. The researcher requested permission to present information about the questionnaire to the residents. These communications occurred one week prior to the administration of the questionnaire. The researcher also requested permission to post announcements as table top tents in the dining room and as a news item on closed circuit television if available.

The questionnaire was distributed to residents as they entered the dining room or left the dining room at lunch and/or dinner in five of the six facilities. One facility requested the

questionnaire be placed in the residents' mail boxes. The researcher was available to assist the residents with reading the instrument or marking their responses. A letter accompanied the questionnaire that described the purpose of the survey. The letter included the compliance information required by IRB, encouraged the residents to complete the instrument, and described the location to return the completed questionnaire (Appendix E). The completed instrument was placed in a sealed box that did not include any identifiers. The sealed box was placed in a convenient location close to the dining room and residents' mailboxes to return their completed questionnaire. Different colored paper was used to identify each facility and to facilitate data coding. Three days after the questionnaire was distributed, the foodservice director was asked to remove the questionnaires from the box and mail the completed questionnaire in a self-addressed postage paid envelope to the researcher.

The researcher conducted an interview with the foodservice director and/or administrator. The researcher interviewed two of the six administrators and six of the foodservice directors (Appendix F).

Data Analysis

SPSS Windows was used for data analysis. Descriptive statistics were used to present a profile of the respondents and the facilities. ANOVA and T-Test were used to assess if types of variables impacted overall satisfaction. The variables analyzed included quality of food, quality of service, atmosphere, meal plans, and frequency of dining with overall satisfaction. ANOVA was conducted to assess the relationship between selected variables, such as frequency of dining, frequency of interaction with chef or foodservice director, and the length of residence and overall satisfaction. T-tests were conducted to determine significant differences between selected variables such as sex, length of stay, generation, dining venues, education level, martial status,

and satisfaction ratings. To determine if there were significant differences between selected demographic variables and satisfaction ratings, the residents were divided into two categories prior to computing T-Test results. Residents' length of stay was categorized as less than five years and greater than five years. Associate degree or lower and bachelor degree or higher were the two categories for educational level of the residents. The two categories used for marital status were married and non-married which included the variables residents who were single, divorced, and widowed. Linear regression and stepwise regression were used to determine if overall satisfaction was influenced by quality of food, quality of service, frequency of dining, atmosphere, dining venues, demographics, and frequency of interactions with chef and foodservice manager.

Upon entering data into SPSS, the question "Employing a chef will improve quality of food" was removed from analysis. A dichotomy of responses was found for this question; the residents responded either 1 or 5. Respondents commented that they already had a chef and could not compare satisfaction should a chef be employed. Chronbach alpha was computed to assess the reliability of the instrument. Hair, Anderson, Tatham, and Black (1998) recommended the Cronbach alpha should exceed 0.70. Results revealed the variables within the instrument were reliable. Cronbach alpha results for each component of the questionnaire were food quality (0.80), service quality (0.71), dining venues (0.75), atmosphere (0.90), and overall satisfaction (0.91).

Results

Demographic Profile

Table 4.2 illustrates the characteristics of the five CCRCs and one retirement community that participated in the study. The number of independent living residents in the facilities ranged from 120 to 1300. All six facilities included a meal plan package within the resident's monthly fee. Two of the facilities had three restaurants and a café/bistro. One facility had a restaurant and café and three of the facilities had only a restaurant as their dining option. All six facilities had either a foodservice director or a staff member who is a chef with culinary experience in a hospitality operation.

The total number of independent living residents in the six facilities was 2,590. Questionnaires were distributed to a total of 759 or 29.27% of the residents. Of the 759 questionnaires distributed, 134 were placed in mailboxes and 625 were distributed at meal times. Of the 759 questionnaires distributed, 480 residents in the six facilities completed the questionnaire for an overall response rate of 63.2% of the surveys distributed or 18.53% of the available population. Table 4.3 illustrates the response rate per facility. Facility B had the lowest response rate (48%) and Facility A had the highest response rate (84%).

Insert Table 4.2

Insert Table 4.3

Table 4.4 presents the demographic profile of the residents who participated in the study. The majority of respondents (66.7%) were females. The average age of the respondents was 80.13± 20.14 years and ranged from 58 to 102 years old. Baby Boomers, GI generation, and Silent generation represented 0.01%, 46.5%, and 52.9%, respectively. The average length of stay at the facilities was 65.46±57.5 months or 5.41±4.79 years. The length of stay ranged from one month to 347 months (29 years). The educational level for the participants ranged from a high school diploma to doctorate degree. The majority (52.5%) of the participants had a bachelor degree or higher.

Insert Table 4.4

Resident Satisfaction

Table 4.5 illustrates residents' rating of satisfaction with the five factors. Satisfaction with atmosphere (4.21±1.00) and satisfaction with service (4.20±1.01) were rated higher than satisfaction with overall dining experience (3.83±1.33) and satisfaction with food quality (3.80±1.13).

Word of mouth satisfaction ratings were higher for residents to say positive things (3.97±1.21) compared to inviting friends (3.88±1.31). Inviting family to dine (3.94±1.31) was rated higher than inviting friends (3.88±1.31). An ANOVA was conducted to determine if there was a significant mean difference between overall word of mouth and frequency of dining. No significance was found between overall word of mouth and frequency of dining ($F=2.64$, $p=0.07$).

Insert Table 4.5

Overall Dining Experience

Table 4.6 illustrates the mean ratings for the measurement items for food quality, service quality, atmosphere, dining venues, and meal plans. Atmosphere (4.40±0.73) and quality service (4.19±0.70) were rated higher than food quality (3.83±0.79), dining venues (3.83±0.89), and meal plans (3.06±1.82).

As illustrated in Table 4.7, food quality, atmosphere, dining venues, and meal plans showed a positive significant relationship with overall satisfaction [R^2=0.61, F=5.51, $p<0.05$]. Within these constructs dining venues had a higher association with overall satisfaction (ß=0.42, $p<0.001$) and meal plans had the lowest association with overall satisfaction (ß=0.07, $p<.05$). The demographic variables marital status (ß=-0.09, $p<0.01$) and length of stay (ß=-0.06, $p<0.05$) had negative significant association with overall satisfaction.

T-Tests were conducted to determine if there was significant relationship between overall satisfaction and the demographic variables: sex, educational level, marital status, generations, and dining venues. Respondents with an education level of bachelor degree or higher (4.05±0.83) had a higher degree of satisfaction compared to residents with less than a bachelor degree (3.93±1.02) at the $p<0.05$ (t=1.08) level of significance. Respondents who lived in facilities with one dining option (4.05±0.87) rated satisfaction higher compared to respondents living in facilities with more than one dining option (3.92±0.0) with a $p<0.01$ level of significance. No significant differences were found between the demographic variables: sex, marital status, and generations and overall satisfaction.

ANOVA results were significantly different for length of stay and overall satisfaction at $p<0.05$ level of significance. Residents who had lived less than 36 months had the highest satisfaction ratings (4.13±0.78). Resident living in the facilities 36 to 72 months had a mean

rating of 3.98±0.86 compared to residents who lived at the facilities greater than 72 months with a mean rating of 3.85±1.12.

Insert Table 4.6

Insert Table 4.7

Food Quality

Table 4.8 illustrates the mean ratings for food quality attributes. The food quality attributes of attractiveness (4.02±0.93) and taste (3.99±0.99) were rated higher than consistency (3.51±1.13) and temperature of food (3.63±1.06). The residents perceived that the food served was healthy (3.90±1.07). Table 4.6 illustrates the mean rating for overall food quality (3.83±0.79) and indicates that the residents were satisfied.

Table 4.9 illustrates the stepwise regression model for overall satisfaction and food quality attributes. The study found that six attributes significantly influenced satisfaction with food quality [R^2=0.44, F=4.37, $p<0.05$]. The six attributes explained 44% of the variance in satisfaction with food quality. The four attributes with the strongest relationship with overall satisfaction with food quality were food items I enjoy (ß=0.17, $p<0.001$), variety of menu items (ß=0.016, $p<0.001$), consistency (ß=0.15, $p<0.01$), and food tastes good (ß=0.18, $p<0.01$).

ANOVA was conducted to compare the means between food quality and length of stay. ANOVA results showed overall food quality satisfaction was strongly related to length of stay at $p<0.01$. Residents who had lived in the facility less than 36 months (3.89±0.83) had a higher satisfaction rating of food quality compared to residents who have lived in the facilities between 37 to 72 months (3.78±0.73) and greater than 72 months (3.85±0.69).

T-Tests were conducted to assess if there were differences in ratings of food quality and selected demographic variables. No significant differences were observed for marital status, educational level, sex, and generation and ratings of overall food quality satisfaction.

Insert Table 4.8

Insert Table 4.9

Service Quality

Table 4.8 illustrates the mean rating for attributes within the service quality construct. The respondents rated respectfulness (4.56±0.85) and appearance of employee (4.17±0.89) higher than service skills (4.07±0.91) and food handling (3.85±1.20).

Table 4.10 illustrates the results of the stepwise regression model for overall satisfaction and service qualities. Five service quality attributes had a strong significant relationship with overall satisfaction [R^2=0.29, F=5.18, $p<0.05$]. The five attributes explained 29% of the variance with overall satisfaction. Stepwise regression found the attributes with the strongest relationship included attentive to needs (ß=0.22, $p<0.01$), neat appearance (ß=0.14, $p<0.01$), menu prices (ß=0.17, $p<0.01$), well trained (ß=0.15, $p<0.01$), and safe food handling (ß=0.10, $p<.05$).

An ANOVA test was conducted to determine if there is a significant mean difference between quality of service and length of stay. ANOVA results were significant at the $p<0.001$. Residents living in the facilities less than 36 months rated satisfaction with quality of service higher (4.26±0.65) compared to residents who live in the facilities between 37 to 72 months (4.14±0.70) and greater than 72 months (4.23±0.59).

T-Tests were conducted to determine if there was a significant mean difference with service quality satisfaction and the following demographic variables; sex, educational level, generations, and marital status. Significant differences were found between the generations ($p<0.05$). The GI generation (4.29±0.04) had a higher satisfaction rating than the Silent generation (4.16±0.05). No significant mean differences were found for sex, marital status, and educational level and overall service quality satisfaction.

Insert Table 4.10

Dining Venues

Table 4.8 illustrates the mean ratings for the dining venue constructs. Having multiple dining options (4.24±1.17) and dining options that promote socialization (4.30±1.02) were rated higher than dining options provided sufficient variety (3.90±1.20) and dining options influenced decision to move into facility (2.92±1.36).

Table 4.7 illustrates that there was a positive association between dining options available and overall satisfaction for individuals already living in the retirement community [$R^2=0.52$, $F=4.06$, $p<0.05$]. T-Test was conducted to determine if there is a significant difference in means between facilities with more than one dining options and overall satisfaction compared to facilities that have only one option. Facility A, E, and F have more than one dining option while Facility B, C, and D have one dining option and were grouped according to this criteria for analysis. A significant mean difference between overall satisfaction and dining options was found ($t=-1.51$, $p<0.01$). The mean satisfaction rating for group Facility AEF (3.92±0.96) was slightly lower compared to Facility BCD (4.04±1.03).

T-Test was conducted to asses if having multiple dining options available increased the frequency of dining. No significant differences were observed between the frequency of dining and the availability of dining options.

Atmosphere

Table 4.6 illustrates the residents indicated that they were satisfied with the dining atmosphere (4.40±0.73). Table 4.8 illustrates that the residents were satisfied with the constructs related to atmosphere. Satisfaction with accessibility of dining rooms (4.43±0.80) was rated higher than comfort (4.39±0.83) and the inviting dining atmosphere (4.39±0.80).

Table 4.7 illustrates results of the stepwise regression model for predicting satisfaction with overall dining experience. Within the dining experience, atmosphere is shown to have a strong association with overall satisfaction [R^2=0.29, F=22.09, p<0.001]. The two attributes that show a significant strong relationship with overall satisfaction are accessibility of dining venues (ß=0.26, p<0.001) and dining venues are inviting (ß=0.32, p<0.001).

ANOVA was conducted to compare means between atmosphere and length of stay. Significant differences were found between satisfaction ratings of atmosphere and the length of stay (p<0.05). Post Hoc analysis revealed that respondents who had lived at the facility between 37 to 72 months rated atmosphere (4.47±0.62) higher than any other time frame (p<0.05).

T-Tests were conducted to determine if there were differences between satisfaction ratings for atmosphere and demographic variables: sex, educational level, generations, and marital status. No significant differences were observed for any of the demographic variables and overall satisfaction with the atmosphere.

Generations, Meal Plans, and Frequency of Interaction

Generations

Table 4.11 illustrates the mean ratings for each facility based on the generation represented by the respondents. The Baby Boomer generation was not used in the statistical analysis since there were only three respondents or 0.01% of the respondents in this generation. The Silent generation (4.09±0.85) rated overall satisfaction higher than the GI generation (3.93±0.99). The residents in the Silent generation had a higher satisfaction rating than the GI generation in all facilities except for Facility B.

Table 4.12 illustrates the linear regression model for predicting satisfaction based on generation. A positive relationship was found between generations and overall satisfaction [R^2=0.04, F=7.54, p<0.01]. A T-test was conducted to assess whether overall satisfaction ratings were different between the GI and Silent generations. No significant differences were found between the two generations (t=-1.85, p=0.14).

Insert Table 4.11

Insert Table 4.12

Meal Plans

All six facilities have a current meal plan which required the residents to eat at least one meal per day as part of the monthly service fee. Three of the facilities were used in the analysis. The analysis was based on the information that was provided in the prescreening of the facilities during the initial contact with the facility. Table 4.6 illustrates the mean satisfaction ratings for meals plans. Overall satisfaction rating for meal plan was 3.06±1.82 indicating that the

respondents were neutral relative to the affect of meal plan and their overall satisfaction. Stepwise regression analysis results indicated a positive relationship with meal plans and overall satisfaction [R^2=0.10, F=50.28, p<0.001].

The frequency of dining at each meal period appears to be related to the meal plan package offered at the facilities. Four of the six facilities designated dinner meals as the meal period that must be used in the plan. On average 408 of the respondents eat dinner in their facility 5.40±1.89 days per week. At lunch, 79 of the respondents eat lunch on average two days per week. Only 56 respondents indicated they ate breakfast an average of one day per week.

Frequency of Visit with Chef and Foodservice Director

The more frequently the residents interact with the foodservice director the higher the satisfaction rating (Table 4.13). Respondents who marked never had a lower satisfaction rating (3.23±0.99) compared to the respondents who marked once per week (4.20±0.85). In the linear regression model, no significant relationship was found between overall satisfaction and frequency of interaction with foodservice director.

Table 4.14 illustrates that the more frequently the respondents interacted with the chef, the higher the satisfaction rating. The respondents who marked that they never interacted with the chef rated overall satisfaction (3.82±0.84) lower than respondents who marked at least one per week frequency (4.31±0.80). Linear regression model illustrated a significant [R^2=0.014, F=6.84, p<0.01] relationship between the frequency of interactions with the chef and satisfaction rating. ANOVA was conducted to determine if there was a significant mean difference between overall satisfaction and frequency of visits with chef. A significant relationship was found between the two variables (F=4.90, p<0.01). Post Hoc analysis revealed a significant mean

difference between satisfaction and frequency of visits with a strong relationship between visits from the chef once a week versus never visiting with the chef ($p<0.01$).

Insert Table 4.13

Insert Table 4.14

Results of Interviews

Two of the facilities have focused on hospitality environment since opening, but the other four implemented this dining approach between one and eight years ago. The change included employing a chef, waitresses, and hostesses and introducing menu changes from institutional type menus to restaurant style menus. The definition of culinary is viewed the same between foodservice directors and administrators. The foodservice directors interviewed described culinary as the art of food and service which encompasses the entire package from food to the atmosphere in the dining room. Culinary was further described as the knowledge to prepare and present food in a way to make people happy and make the dining experience exciting. The administrators described culinary as an operation's attempt to engage residents by providing new cooking skills while enhancing the aesthetics of the dining area.

The primary reason for hiring someone with a culinary background was to increase the skill level within the cook level positions since improved quality was an expectation of the residents. Since changing the skill level within the foodservice operations, four of the six facilities reported observing higher customer satisfaction. The satisfaction is being assessed through use of surveys, word of mouth, and how frequently the dining venues are being used by the residents.

Both administrators and foodservice directors had similar ideas on future changes they would like to implement their foodservice operations. One of the main areas of focus is to increase the daily hours of operation at the facilities and extend to seven days a week. Currently all facilities are not open seven days a week and not for all three meals.

The foodservice directors and administrators also would like to see a change in the meal plan system. Several administrators and foodservice directors indicated the meal plan system needs to be more flexible so residents can choose when and where they eat instead of forcing them to eat at a specific meal for their meal plan. One foodservice director plans to explore the feasibility of a debit system rather than a meal plan. This change would provide the choices and allow the residents more flexibility in how they schedule daily activities.

Each foodservice director and administrator provided ideas about how they could enhance the dining options available to residents. One administrator and six foodservice directors stated they would like their facility to provide other dining options such as an additional bistro or coffee shop, bar and grill, ultra formal dining, pub, and a full liquor license. One foodservice director plans to enhance service standards and develop a strong training program to help promote consistency and food quality. However, several foodservice directors are concerned about the potential impact on the current "community feeling" provided by the one dining venue if they open additional dining venues. One dining option offers an opportunity for residents to come together at least once daily. An additional dining venue could create a feeling of the community disconnect. The distance between dining venues and where people live could present problems for some residents. If the dining options are too far away, it makes it more difficult for residents to get to the different dining options.

Only two facilities indicated that their dining venues were open to some extent to the public. Since all are not-for-profit, they are not allowed by tax laws to advertise to the public. Four facilities allow guests to dine in their dining venues by resident invitation only. Two facilities allow staff to dine in the same dining venues as the residents.

Discussion and Implications

The purpose of this study was to assess residents' overall satisfaction with quality of food and quality of service in CCRCs and retirement communities when the community employs a foodservice director or chef with culinary experience.

A positive significant relationship was found between food quality and overall satisfaction. No significant relationship was observed between quality service and overall satisfaction. Quality of service had a higher mean rating than food quality with overall satisfaction. This result is consistent with previous research. Seo and Shanklin's (2005) and Howells' (2007) studies reported that residents in assisted living and independent living rated food quality lower than service quality. Satisfaction with quality of service was rated higher than satisfaction with food, but did not significantly influence overall satisfaction with dining as compared to food quality. Atmosphere, dining venues, and meal plans also showed a positive significant relationship with overall satisfaction.

The two demographics that impacted overall satisfaction were length of stay at the facilities and educational level. Residents who had lived in the facilities less than 36 months had higher satisfaction ratings. Friedland (2000) noted that residents moving into CCRCs and retirement communities today demand higher quality of food than residents who currently live in CCRCs and retirement communities. Residents with a bachelor degree or higher had higher

satisfaction rating than residents with less education. Sex, marital status, and generations did not affect overall satisfaction ratings.

Overall satisfaction is significantly influenced by individual food quality attributes. The four attributes with the strongest relationship were food items I enjoy, variety of menu items, consistency, and food tastes good. The food quality attributes with the lowest mean ratings were temperature, consistency served, tenderness of food served, and variety of menu items. The food quality attributes that were rated low were the same attributes that the residents suggested needed improvement in their response to the open ended question. Residents wanted more options for special diets, healthy choices, less spice and seasoning, fresh vegetables versus frozen vegetables, improvement on food temperatures, and tenderness of meat products. Length of stay was found to influence food quality satisfaction. As the residents' length of stay increased, the overall satisfaction with food quality decreased.

Individual service quality attributes had a significant relationship with overall satisfaction. The five attributes were attentive to needs, neat appearance, menu prices, well trained servers, and safe food handling. The service quality attributes with the highest mean ratings were attentiveness and respectfulness. Seo and Shanklin (2005) study also found these two attributes to have high satisfaction ratings with service quality. Suggestions from the residents on the questionnaire within service quality supported these attributes. Residents commented that the waiters and waitresses were friendly, courteous, attentive to needs, and personally knew them. Lower satisfaction ratings for service quality were found for service skills and food handling. Residents commented in the survey that they can tell when inadequate training of the servers has occurred by how the dining room looks and feels along with how the food is served.

A significant correlation was found between length of stay, generations, and satisfaction ratings of service quality. Residents who lived at the facilities less than 36 months had a higher satisfaction rating compared to any other time. Residents who were categorized in the GI generation had a higher satisfaction rating for the quality of service compared to the Silent generation.

In this study, three facilities offer more than one dining venue to the residents. The results from the study showed that the group with more than one dining option had a slightly lower satisfaction rating compared to the groups that had one dining option. This is contrary to what is being described in literature. The literature may be focusing on what the baby boomers will be demanding compared to the current generations that are living in CCRCs and retirement communities (Bulzalka, 2005; Holmes, 2006). The majority (99.4%) of the respondents were from the GI and Silent generations and may not value multiple dining options as impacting overall satisfaction as much as the upcoming generation.

Three facilities were used to analyze if meal plans influence overall satisfaction. All three facilities included a meal plan package in the monthly fee. Meal plans were found to influence residents' overall satisfaction ratings, but the mean rating indicated the residents were neutral relative to the affect of meal plan and their overall satisfaction. In the interviews with the administrators and foodservice directors, many expressed that their goal is to expand the meal plan package to allow residents to choose their meal using a meal plan debit system. Foodservice directors and administrators need to focus on what type of meal plan system works for their facility but encourage more choices of how the meal plan can be used. There are financial implications when changing meal plans that will have to be carefully assessed. Many facilities have their current meal plan system organized to only allow for one meal per day and

typically the facility mandates it can only be at designated meals. In this type of setting the budget is easier to manage; the number of residents who will be eating in the dining venues can be forecasted based on the designated meal time as established in the meal plan. When a meal plan system moves to a debit system or choice, forecasting demand is more challenging and food cost may increase. Since the decision of type of meal plan could significantly impact the operating budget and residents' satisfaction, the foodservice director and administrator will have to carefully assess the feasibility of each option.

The more frequently the chef and foodservice director interacted with the residents, the higher the satisfaction. Within this study, the residents rated the satisfaction level higher when interacting with the chef compared to the foodservice director. This may be related to the value placed on the perception of chef skills versus foodservice director skill level with quality of food and services provided (Brandon and Flury, 2009; Cavanaugh, 2003; Lee et al., 2003). Having the chef complete daily rounds at meal time can develop better relationships with the residents. Ultimately, this should improve overall satisfaction.

The administrators and foodservice directors employed by the facilities had very similar perceptions about customer satisfaction and dining. All facilities have hired a person with culinary background because the residents and administration place value on this skill and the trend of changing from institutional food to higher quality of foods linked with fine dining. All the administrators and foodservice directors reported observing a change in customer satisfaction since employing a chef and modifying the dining atmosphere. The administrators and foodservice directors commented the continual need to improve overall satisfaction and one area of focus is providing more choices to the residents.

Knowledge of factors influencing residents' satisfaction can assist foodservice directors and administrators in understanding what the customers are looking for and how to improve overall services. Food quality is one of the top areas they should focus and the attributes identified by residents should the focus of their improvement. While focusing on areas that need improvement, food service directors and administrators should not ignore atmosphere and service quality which were rated satisfactory in this study. Atmosphere of the dining venues will be important as the baby boomer generation become more prevalent in CCRCs, creating the need to balance expectations with all three generations (Bulzalka, 2005).

Foodservice directors and administrators need to recognize that the trend is to provide more food choices. Their challenge is to determine the type of dining options the residents want and what the type of service the residents are expecting. This will continue to be a struggle as the communities continue to grow and more baby boomers begin moving into CCRCs and retirement communities. Balancing the needs of all three generations will be a challenge and should be carefully explored for both current and future residents. A recommendation would be to conduct a survey in approximately five years when more of the baby boomer generation will be residing in CCRCs and retirement communities to determine if the multiple dining options and meal plans impact overall satisfaction.

A limitation of this study is that it was conducted in only six facilities in the Midwest and results cannot be generalized to all regions of the United States. Within the Midwestern region it was limited to three states and a limited number of facilities. Further research should be conducted in the Midwestern region and other regions within the United States. Another potential limitation is the length of survey. Physical abilities, such as poor eyesight and mental capabilities relating to memory, can create a limitation to the study. The foodservice directors

recommended distributing the surveys before and after meal times, which can limit the number of individuals who received the survey. Another limitation to the study is that the survey may have been completed based on their residents' regency experience instead of an overall perception since moving to facility.

Further research can be conducted to determine what attributes influence residents to move into a CCRC. There are many articles discussing the perception of attributes that impact influence but no current research to confirm these attributes. This type of research can be important for administrators to assure that the organizations focus on the attributes that influence a resident to move into CCRCs and retirement communities. Future studies should explore the impact of changing the meal plan option to allow more individual choices or a meal plan deductions system and residents' satisfaction. Previous studies have shown that the older population eats their largest meal in the evening and it would be interesting to see if this trend will continue if meal plan choices are allowed.

References

Anonymous. (2008). Menu trends. *FoodService Director,* 21(4), 12-2.

Anonymous. (Dec 2009). Lap of Luxury. *Long-Term Living*. 58 (12), 19-22.

Administration on Aging. (2009). *A profile of older Americans: 2009*. Retrieved from http://www.aoa.gov

Aramark. (2008). *What seniors think about CCRCs: What's important to your residents and prospective residents*. Retrieved from http://www.aramark.com

Brandon, B., & Flury, E. (Jan 2009). Aging with choice: Coping with a changing marketplace. *Long-Term Living*. 58 (1), 15-18.

Briley, M. E. (1994). Food preferences of the elderly. *Nutrition Reviews,* 52(8), S21.

Buzalka, M. (2005). What does the future hold for CCRCs? *Food Management,* 40(9), 40.

Cavanaugh, B. B. (2003). Upscale dining drives sales at Hyatt Retirement Village-news-Hyatt at the glen. *Nation's Restaurant News*

Dube, L., Renaghan, L. M., & Miller, J. M. (Feb 1994). Measuring customer satisfaction for strategic management. *Cornell Hotel and Restaurant Administration Quarterly,* 35(1), 39-48.

Fox, T., Brummit, P. S., Ferguson-Wolf, M., Abernethy, M., & et al. (2000, May). Position of the american dietetic association: Nutrition, aging, and the continuum of care. *Journal of American Dietetic Association,* 100(5), 580.

Friedland, A. (2000, November). Senior dining, A revolution in the making? *Food Management,* 35(11), 44-48.

Groger, L., & Kinney, J. (2006). CCRC here we come! reasons for moving to a continuing care retirement community. *Journal of Housing for the Elderly, 20*(4), 79.

Hair, J.F., Anderson, R.E., Tatham, R.L., & Black, W.C. (1998). Multivariate Data Analysis (5th ed.). New Jersey: Prentice Hall.

Holmes, S. (2006). Barriers to effective nutritional care for older adults. *Nursing Standard, 21*(3)

Huang, H. (2004). Factors affecting satisfaction and residents' utilization of foodservice in assisted living facilities. Unpublished doctoral dissertation, Kansas State University, Kansas.

Howells, A. (2007). The impact of perceived quality on assisted living residents' satisfaction with their dining experience. Unpublished master dissertation, Kansas State University, Kansas.

International Food Information Council. (2001). Exploring the food and health attitudes of older Americans. *Journal of Nutrition for the Elderly,* 20(3), 39-44.

Jhaveri, T.S. (2006). Enhancing the dining experience in senior living. *Nursing Homes,* 55(10), 56.

Lawn, J. (1996, November). A retirement community transition. *Food Management,* pg. 40-48.

Lee, K., Shanklin, C. W., & Johnson, D. E. (2003). Development of service quality measurement for foodservice in continuing care retirement communities. *Foodservice Research International*, pg. 1-21.

Northern Services Group Inc. (2007). Northern hospitality: Creating a hospitality culture in a nursing home setting. pg. 26-35.

Seo, S., & Shanklin, C. W. (2005). Important food and service quality attributes of dining service in continuing care retirement communities. *Journal of Foodservice Business Research,* 8(4), 69-86

Watkins, C. (1998, June). New bistro at CCRC increases customer satisfaction, provides competitive advantage. *Food Management,* 33(6), 20.

Table 4.2-Description of Continuing Care Retirement Community (CCRC) and Retirement Community

Facilities	Types of Operation[1]	Dining Venues	Meal Plan[2]	Culinary Experience	Number of Residents
Facility A	CCRC	Three Restaurants Café	One meal per day included in monthly rent	Director of Dining (hospitality management w/ MBA) Corporate Chef	700
Facility B	CCRC	Restaurant	One meal per day included in monthly rent	Director of Dining (political science) Certified Chef	120
Facility C	CCRC	Restaurant	One meal per day included in monthly rent	Director of Dining (Certified Dietary Manager and 20 yrs of restaurant experience) Certified Chef	200
Facility D	Retirement Community	Restaurant	One meal per day included in monthly rent	Director of Dining (Chef)	120
Facility E	CCRC	Restaurant Bistro	Meal Plan Credit System	Director of Dining (Hospitality Degree and Restaurant Experience)	150
Facility F	CCRC	Three Restaurants Café Bistro	One meal per day included in monthly rent	Director of Dining (Hospitality Degree and Restaurant Experience) Chef	1300

[1]Participants were residing in the independent living units of these facilities.
[2]Designated meals for the meal plan were dinner in facilities A, B, C, D and choice of lunch or dinner in facilities E and F.

Table 4.3-Response Rate Per Facility

Facility	Total # of Surveys Distributed[1]	Total # of Surveys Returned	Response Rate
Facility A	232	195	84.1%
Facility B	84	40	47.6%
Facility C	107	60	56.1%
Facility D	53	33	62.3%
Facility E	150	74	49.3%
Facility F	133	78	58.6%
Overall	759	480	63.2%

[1]Surveys were distributed at meal time except for facility E where the surveys were placed in residents' mailboxes based on administrators' request.

Table 4.4-Demographics Profile of Respondents

	Facilities													
	Overall		A		B		C		D		E		F	
Demographic Variable	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Sex														
Male	147	30.6	62	31.8	22	27.8	23	31.5	18	29.5	12	30.8	10	30.3
Female	320	66.7	127	65.1	53	67.1	49	67.1	43	70.5	26	66.7	22	66.7
Marital Status														
Married	195	40.6	93	47.7	28	35.4	25	34.2	21	34.4	12	30.8	16	48.5
Non Married	274	57.1	97	49.7	49	62.1	47	64.4	39	63.9	26	66.7	16	48.5
Age														
Silent Generation	212	46.5	76	39.0	36	45.6	18	24.7	39	63.9	19	48.7	24	72.7
GI Generation	241	52.9	109	55.9	38	48.1	48	65.8	22	36.1	16	41.0	8	24.2
Baby Boomers	3	0.01	0	0	0	0	3	4.1	0	0	0	0	0	0
60-69	9	2.0	1	0.5	0	0	7	9.8	1	1.6	0	0	0	0
70-79	74	15.3	34	17.2	7	8.9	20	27.4	2	3.2	9	20.5	3	9.0
80-89	273	56.9	116	59.5	46	58.2	35	48.0	40	65.7	17	43.5	19	57.7
90-99	95	18.8	32	16.4	18	22.8	7	9.6	19	29.4	10	25.8	10	30.2
100-109	3	0.6	1	0.5	2	2.6	0	0	0	0	0	0	0	0
Length of Stay in Months														
0-36 months	182	34.5	41	20.8	41	53.4	49	71.2	31	52.1	10	25.7	9	27.2
37-72 months	115	23.8	55	23.4	12	15.3	6	8.2	20	32.6	13	33.4	12	36.3
>72 months	167	34.8	93	47.7	21	27.0	15	20.6	12	19.4	15	38.6	11	33.3
Education Level														
Elementary	3	0.6	1	0.5	0	0	0	0	1	1.6	0	0	1	3.0
High School	105	21.9	39	20.0	8	10.1	26	35.6	8	13.1	10	25.6	14	42.4
Associate Degree	47	9.8	21	10.8	5	6.3	9	12.3	8	13.1	2	5.1	2	6.1
Bachelor Degree	162	33.8	75	38.5	32	40.5	16	21.9	18	29.5	17	43.6	4	12.1
Master Degree	75	15.6	32	16.4	12	15.2	12	16.4	9	14.8	5	12.8	5	15.2
Doctoral Degree	15	3.1	3	1.5	1	1.3	3	4.1	6	9.8	1	2.6	1	3.0
Other	57	11.9	17	8.7	18	22.8	6	8.2	10	16.4	3	7.7	3	9.1

Table 4.5-Residents' Satisfaction Ratings with Food, Service, Atmosphere, and Overall

	Facilities													
	Overall N=480		A N=195		B N=79		C N=73		D N=61		E N=39		F N=33	
Factors	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
I am satisfied with the atmosphere.	4.21	1.00	4.27	1.02	4.11	0.85	4.27	0.80	4.21	1.10	3.79	1.45	4.42	0.61
I am satisfied with the service provided by wait staff.	4.20	1.01	4.22	1.02	4.20	0.83	4.26	0.99	4.00	1.11	4.31	1.24	4.21	0.96
I will say positive things	3.97	1.21	3.79	1.29	3.96	1.26	4.10	1.03	4.11	1.27	4.15	1.16	4.24	0.87
I will invite my family	3.94	1.31	3.68	1.42	4.05	1.19	4.10	1.09	4.10	1.36	4.15	1.27	4.24	1.15
I will invite my friends	3.88	1.31	3.59	1.46	4.06	1.07	3.96	1.16	4.10	1.23	4.18	1.21	4.21	1.14
I am satisfied with the overall dining experience.	3.83	1.33	3.78	1.38	3.70	1.38	4.05	0.93	3.90	1.39	3.74	1.62	3.97	1.13
I am satisfied with the quality of food served.	3.80	1.13	3.59	1.22	3.73	1.04	3.93	0.93	4.18	1.01	3.85	1.35	4.12	0.82

Note: Rating scale was a 5 point Likert scale with 1, strongly disagree and 5, strongly agree.

Table 4.6-Residents in Continuing Care Retirement Communities and Retirement Communities Mean Ratings for Overall Satisfaction

	Facilities													
	Overall N=478		A N=194		B N=79		C N=73		D N=61		E N=39		F N=33	
Variables	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1 (constant)														
Atmosphere	4.40	0.73	4.47	0.75	4.40	0.71	4.33	0.81	4.27	0.60	4.37	0.78	4.43	0.66
Service Quality	4.19	0.70	4.15	0.69	4.14	0.69	4.22	0.81	4.24	0.56	4.28	0.78	4.32	0.64
Food Quality	3.83	0.79	3.73	0.80	3.78	0.89	3.85	0.79	4.10	0.62	3.83	0.78	3.97	0.72
Dining Venues	3.83	0.89	3.81	0.91	3.97	0.74	3.83	0.78	3.80	1.05	3.63	1.24	3.92	0.64
Meal Plans	3.06	1.82	3.61	1.40	3.46	1.37	3.70	1.33	3.62	1.51	0	0	0	0

Note: Rating scale was a 5 point Likert scale with 1, strongly disagree and 5, strongly agree.

Table 4.7-Stepwise Regression Model for Predicting Residents' Satisfaction with Overall Dining Experience Related to Five Measurement Items

Overall Dining Attributes				
Measurements	B	SE B	ß	*t*
Dining Venues	0.45	0.04	0.42	12.83***
Food Quality	0.44	0.04	0.37	10.47***
Atmosphere	0.18	0.05	0.14	4.02***
Marital Status	-0.13	0.04	-0.09	-3.12**
Meal Plan	0.04	0.02	0.07	2.35*
Length of Stay	-0.06	0.03	-0.06	-2.10*

Note: R^2=0.61; Adjusted R^2=0.61
***p<.001, **p<.01, *p<.05
(Attributes excluded: quality service.)

Table 4.8-Residents in Continuing Care Retirement Communities and Retirement Community Mean Ratings for Attributes

	Facilities													
	Overall N=479		A N=194		B N=79		C N=73		D N=61		E N=39		F N=33	
Measurements	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Food Quality														
Attractiveness	4.02	0.93	3.89	0.96	3.94	1.01	4.08	0.94	4.20	0.85	4.14	0.82	4.36	0.55
Taste	3.99	0.99	3.89	0.97	3.89	1.03	4.04	0.96	4.30	0.84	4.05	1.00	4.06	1.20
Healthy	3.90	1.07	3.74	1.11	3.94	1.11	3.81	1.15	4.38	0.58	3.90	1.02	4.09	1.16
Enjoyment of Food	3.86	1.10	3.82	1.11	3.73	1.26	3.84	1.13	4.05	1.01	3.96	0.98	4.03	0.85
Tenderness	3.60	1.10	3.53	1.09	3.63	1.09	3.68	1.25	3.85	0.87	3.33	1.24	3.60	1.00
Temperature	3.63	1.06	3.57	1.05	3.56	1.09	3.60	1.30	3.75	0.91	3.72	0.79	3.82	1.07
Consistency	3.51	1.13	3.24	1.21	3.48	1.11	3.80	0.94	3.93	0.85	3.54	1.27	3.70	0.95
Service Quality														
Respectfulness	4.56	0.85	4.57	0.84	4.52	0.92	4.42	1.09	4.62	0.52	4.69	0.86	4.64	0.55
Attentiveness	4.32	0.90	4.34	0.77	4.20	1.06	4.37	0.92	4.34	0.81	4.31	1.28	4.30	0.77
Employee's Appearance	4.17	0.89	4.09	0.90	4.20	0.87	4.05	1.03	4.20	0.79	4.44	0.85	4.39	0.66
Service Skills	4.07	0.91	4.06	0.91	3.91	0.87	4.16	1.02	4.08	0.78	4.23	0.84	4.15	1.06
Food Handling	3.85	1.20	3.70	1.25	3.86	1.09	4.09	1.12	3.93	1.17	3.74	1.45	4.12	1.05
Menu Prices	3.36	1.68	2.94	1.79	3.87	1.11	4.01	0.98	2.57	2.12	4.26	1.07	3.58	1.75
Atmosphere														
Accessibility	4.43	0.80	4.53	0.77	4.46	0.73	4.36	0.84	4.16	.800	4.44	0.94	4.39	0.75
Comfortable	4.39	0.83	4.42	0.87	4.42	0.84	4.34	0.93	4.25	.675	4.41	0.75	4.48	0.62
Inviting	4.39	0.80	4.47	0.81	4.33	0.81	4.30	0.85	4.39	.585	4.27	0.90	4.42	0.87
Dining Venues														
Socialization	4.30	1.02	4.40	1.01	4.33	0.90	4.10	0.97	4.21	1.10	4.15	1.48	4.42	0.61
Multiple Options	4.24	1.17	4.24	1.13	4.42	0.98	4.47	0.88	4.00	1.40	3.92	1.58	4.15	1.28
Sufficient Variety	3.87	1.18	3.82	1.26	3.91	1.03	3.84	1.18	4.05	1.10	3.59	1.45	4.18	0.77
Influenced Decision to Move	2.92	1.36	2.80	1.28	3.22	1.44	2.93	1.29	2.92	1.48	2.87	1.45	2.91	1.47
Frequency														
Meal Plan[1]	3.06	1.82	x	x	3.46	1.37	3.70	1.33	3.62	1.51	x	x	x	x

Note: Rating scale was a 5 point Likert scale with 1, strongly disagree and 5, strongly agree.
[1]Facilities with x in meal plan section represents data not collected for these facilities on meal plan satisfaction based on initial information provide by foodservice directors.

Table 4.9-Stepwise Regression Model for Predicting Residents' Satisfaction with Food Served Based on Food Quality Variables

Food Quality Attributes				
	B	**SE B**	**ß**	***t***
Food Tastes Good	0.18	0.05	0.18	3.42**
Consistency	0.13	0.04	0.15	3.01**
Food Items I Enjoy	0.15	0.04	0.17	3.65***
Variety of Menu Items	0.15	0.04	0.16	3.73***
Attractively Presented	0.11	0.05	0.11	2.16*
Appropriate Temperatures	0.08	0.04	0.09	2.09*

Note: R^2=0.44; Adjusted R^2=0.44
***p<.001, **p<.01, *p<.05
(Attributes excluded: food is tender, food is healthy.)

Table 4.10- Stepwise Regression Model for Predicting Residents' Satisfaction with Services Based on Service Quality Variables

	B	**SE B**	**ß**	***t***
Attentive to Needs	0.24	0.05	0.22	4.67**
Neat Appearance	0.16	0.05	0.14	2.97**
Attentive to Needs	0.10	0.02	0.17	4.24**
Well Trained	0.16	0.05	0.15	2.88**
Safe Food Handling Practice	0.08	0.04	0.10	2.28*

Note: R^2=0.29; Adjusted R^2=0.29
***p<.001, **p<.01, *p<.05
(Attributes excluded: treat with respect.)

Table 4.11- Means for Generation Categories and Overall Satisfaction

	Facilities													
	Overall N=453		A N=195		B N=79		C N=72		D N=61		E N=38		F N=32	
Category	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Silent Generation	4.09	0.85	3.95	0.93	3.98	0.91	4.16	0.79	4.43	0.39	4.53	0.54	4.43	0.79
GI Generation	3.93	0.99	3.84	1.04	4.01	0.84	4.09	0.53	3.89	1.19	3.85	1.23	4.13	0.72

Note: Rating scale was a 5 point Likert scale with 1, strongly disagree and 5, strongly agree.
Note: Baby Boomer Generation excluded due to only 0.01% of population surveyed.

Table 4.12- Regression Model for Predicting Satisfaction Based on Generation Categories

Facilities	B	SE B	B	t
A	0.34**	0.12	0.19	2.75
B	0.06	0.16	0.04	0.36
C	0.08	0.14	0.07	0.57
D	0.54*	0.26	0.26	2.04
E	0.78**	0.25	0.46	3.15
F	0.27	0.27	0.18	1.01
Overall	0.28***	0.07	0.17	3.81

Note: Rating scale was a 5 point Likert scale with 1, strongly disagree and 5, strongly agree.
*p<.05, **p<.01, ***p<.001

Table 4.13-Means for Frequency of Visit with Foodservice Director and Overall Satisfaction

	Facilities													
	Overall N=469		A N=191		B N=77		C N=70		D N=42		E N=38		F N=32	
Frequency	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Once per Week	4.20	0.85	4.10	0.86	4.22	0.87	4.07	1.25	4.18	0.69	4.55	0.53	4.37	0.69
Occasionally	3.99	0.90	3.94	0.91	3.92	0.87	4.21	0.51	4.22	0.96	3.57	1.37	3.99	0.80
Once per Month	3.89	1.14	3.45	1.54	4.51	0.63	3.86	0.51	4.54	0.42	3.48	1.37	0.00	0.00
Never	3.73	0.99	3.63	1.01	3.70	1.08	3.82	0.61	3.72	1.23	4.42	0.66	4.29	0.00

Note: Rating scale was a 5 point Likert scale with 1, strongly disagree and 5, strongly agree.

Table 4.14-Means for Frequency of Visit with Chef and Overall Satisfaction

	Facilities													
	Overall N=466		A N=190		B N=78		C N=70		D N=58		E N=38		F N=32	
Frequency	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Once per Week	4.31	0.80	4.28	0.65	0.00	0.00	3.77	1.64	3.77	1.64	4.57	0.39	4.48	0.54
Occasionally	4.06	0.10	3.92	1.00	4.34	0.83	4.22	0.49	4.22	0.49	4.04	1.40	3.92	0.78
Once Per Month	3.96	1.16	3.79	1.29	0.00	0.00	0.00	0.00	0.00	0.00	4.64	0.30	3.81	1.15
Never	3.82	0.84	3.72	0.95	3.78	0.84	4.08	0.60	4.08	0.60	3.86	0.57	0.00	0.00

Note: Rating scale was a 5 point Likert scale with 1, strongly disagree and 5, strongly agree.

CHAPTER 5 - Summary and Conclusions

The purpose of the study was to assess residents' overall satisfaction with quality of food and quality of service in Continuing Care Retirement Communities (CCRC) and retirement communities when the facility employs a foodservice director or chef with culinary training or expertise. The objectives of this study were as follows: (1) Assess the level of overall satisfaction with the quality of food and services provided by foodservice, (2) Determine if providing different dining venues increases overall satisfaction, (3) Explore the effect of requiring a meal plan on customer satisfaction and frequency of dining, (4) Explore if the frequency of interaction with the chef or foodservice manager influences customer satisfaction and (5) Assess if demographic characteristics such as sex, generations, marital status, and length of stay effect overall customer satisfaction.

The research questions addressed were as follows: (1) Has administration noticed a change in overall customer and staff satisfaction in the restaurant/dining room since employing someone who has culinary experience? (2) What is the residents' satisfaction with food and service quality? (3) Does having a required meal plan influence overall customer satisfaction? (4) Does the frequency of interaction of residents with the chef or foodservice manager influence overall customer satisfaction? and (5) Do the demographic characteristic of residents which includes sex, marital status, and length at facility influence overall customer satisfaction?

Major Findings

Food Quality, Service Quality, and Overall Satisfaction

A positive significant relationship was found between food quality and overall satisfaction. Quality of service had a higher mean rating than food quality with overall

satisfaction. This is consistent with previous research. Seo and Shanklin's (2005) and Howells' (2007) studies reported that residents in assisted living and independent living rated food quality lower than service quality. This study shows that quality of service is rated high with the residents in satisfaction, but is not what significantly influences overall satisfaction with dining as compared to food quality. Atmosphere, dining venues, and meals plans also showed a positive significant relationship with overall satisfaction.

The food quality variables attractiveness (4.02±0.93) and taste good (3.99±0.99) were rated higher than consistency (3.51±1.13) and temperature of food (3.63±1.06). Six food quality attributes significantly influenced satisfaction. The four attributes with the strongest relationship with overall satisfaction and food quality were food items I enjoy, variety of menu items, consistency, and food tastes good. The food quality attributes with the lowest mean ratings were temperature of food served, consistency of food served, tenderness of food served, and variety of menu items. The food quality attributes that were rated low were the same attributes that the residents suggested needed improvement in their response to the open ended questions. Residents want more options for special diets, healthy choices, less spice and seasoning, fresh vegetables versus frozen vegetables, improvement of food temperatures, and the tenderness of meat products.

The residents rated service quality variables attentive to need (4.32±0.90) and appearance of employee (4.40±0.66) higher than service skills (4.20±1.06) and food handling (4.10±1.05). A significant relationship was found between service quality attributes and overall satisfaction. The five service quality attributes were attentive to needs, neat appearance, menu prices, well trained servers, and safe food handling. Suggestions from the residents on the questionnaire within the service quality supported satisfaction ratings of these attributes. Residents

commented that the waiter and waitress are friendly, courteous, attentive to needs, and personally know the residents. The service quality attributes rated the lowest were service skills and food handling. Residents completing the survey commented that they can tell when inadequate training of the servers has occurred by how the dining room looks or how the food is served. Significant mean difference was found between GI and Silent generations ratings of service quality. The GI generation (4.29±0.04) was more satisfied with service quality than the Silent generation (4.16±0.05).

Demographics and Overall Satisfaction

Significant differences were found between length of stay and overall satisfaction at $p<0.05$ level of significance. Residents who lived in the facility for less than 36 months had higher satisfaction ratings compared to any other time frame. This may be related to the differences in expectations relative to choice and variety between the generations that are moving into CCRCs and retirement communities. Residents just moving into the facility have higher satisfaction ratings with the choices and variety compared to residents who have lived at the facility longer and may not like the change. Friedland (2000) noted that residents moving into CCRCs and retirement communities today demand higher quality of food than residents who currently live in CCRCs and retirement communities.

Education level affected overall satisfaction ratings. Respondents with an education level of bachelor degree or higher (4.05±0.83) rated satisfaction higher than residents with less than a bachelor degree (3.93±1.02) at $p<0.05$ ($t=1.08$) level of significance. Education level can impact income level. Baker (2007) noted individuals with lower income levels had less variety in food knowledge and choice compared to individuals with higher income level. Individuals with higher income levels have more opportunity to travel and dine in different venues, thus they

expect more choices in the type of food and service provided in CCRCs and retirement communities.

Dining Venues and Overall Satisfaction

In the study, residents were divided into two groups based on if the facility had one or more dining options. Three out of six facilities had more than one dining option. A positive association was found between dining options available and overall satisfaction for individuals living in the retirement community at $p<.001$. Residents in CCRCs and retirement communities with more than one dining option had slightly lower satisfaction ratings (3.92 ± 0.96) compared to the group that had one dining option (4.04 ± 1.03). This is contrary to what is noted in literature. In this study, a majority of the respondents were from the GI generation and Silent generation. These individuals may not value multiple dining options compared to the Baby Boomer generation that is now moving into CCRCs and retirement communities (Bulzalka, 2005; Holmes, 2006).

Foodservice directors and administrators should recognize the importance of choices; however, more market research is needed to determine the type of dining options the residents want and what type of service the residents are expecting. This will continue to be a struggle as the CCRCs and retirement communities continue to grow and more baby boomers move into these communities. Balancing the needs of all three generations will be a challenge. Foodservice directors should continually assess variables influencing residents' satisfaction and determine operation changes required to enhance customer satisfaction.

Meal Plans and Overall Satisfaction

Three facilities in the research were used to conduct analysis on the affects of meal plan on overall satisfaction. The meal plans were found to influence residents' overall satisfaction at $p<0.05$. Respondents rated satisfaction with the meal plan as 3.06±1.82, thus respondents were neither satisfied nor dissatisfied with the meal plan options available.

The study found the frequency of dining was positively influenced by meal plan requirements in the facilities. A high percentage number of respondents marked agree to strongly agree (52%) compared to the number of respondents marked disagree to strongly disagree (8%) for the impact of meal plans on the frequency of when they dine at the CCRC.

In interviews with the administrators and foodservice directors, many expressed that their goal is to expand the meal plan package to allow residents to choose as to which meal the meal plan can be used for or changing to a meal plan debit system. Foodservice directors and administrators need to determine the type of meal plan system that works for their facility but encourage more choices of how the meal plan can be used. Since the decision of type of meal plan could significantly impact the operating budget and residents' satisfaction, the foodservice director and administrator will have to carefully assess the feasibility of each option.

Frequency of Visits from Food Service Director and Chef with Overall Satisfaction

The more frequently the foodservice director and chef interacted with the residents, the higher the residents' satisfaction rating. Residents who marked never to the frequency they interacted with the foodservice director (3.72±1.00) had a lower satisfaction ratings compared to the respondents who marked once per week (4.20±0.85). The residents who indicated they never interacted with the chef had a lower overall satisfaction rating (3.82±0.84) than respondents who marked at least one per week frequency (4.31±0.80). The frequency residents interacted with the

chef significantly influenced their satisfaction ratings. No significant differences were found for the frequency the foodservice director interacted with the residents and their overall satisfaction. This may be related to the value placed on the perception of chef skills versus foodservice director skill level (Brandon and Flury, 2009; Cavanaugh, 2003; Lee, Shanklin and Johnson, 2003).

Perception of Administrators and Foodservice Directors on Overall Satisfaction

All facilities had hired a person with culinary background because the residents and administration place value on this skill level and the trend of moving from institutional food to fine dining quality in food. Since employing a chef, the administrator and foodservice director reported observing improvement in satisfaction based on dining satisfaction surveys and a decrease in the number of complaints received about food quality. For foodservice directors and administrators, this is an important aspect in improving overall customer satisfaction. Having the chef complete daily rounds at meal time can develop better relationships with the residents. They can hear the concerns and compliments first hand and can make immediate improvement to address expressed concerns. Ultimately, this will help improve residents' overall satisfaction with the quality of food and service provided.

Conclusions and Implications

Results of this study can assist foodservice directors and administrators to understand what the customers are looking for and how to improve overall food and service quality and residents' satisfaction. Food quality is one of the most important attributes that must be maintained since it impacts residents' quality of life. The importance residents place on food quality cannot be ignored even by facilities that have employed chefs. Even though having

someone with culinary experience is perceived to increase food quality, administrators must continually evaluate residents' satisfaction since employing a chef does not eliminate all problems. Management should not ignore the areas that have high satisfaction ratings, such as atmosphere and service quality while focusing on attributes rated lower.

Meal plans are not uncommon within CCRCs and retirement communities, but how the meal plans are implemented is changing. Since the baby boomer generation expects more choices, the administrators will need to determine the type of meal plan system that results in higher customer satisfaction among the different generations living in the facility. The respondents' ratings were neutral relative to the affect of meal plan and overall satisfaction; however, only the Silent and GI generations were included in the analysis since there were only three respondents in the Baby Boomer generation.

The meal plan system was found to impact how frequently residents ate in the dining venues available. Many facilities have their current meal plan system that includes one meal per day in their monthly fee. Typically the facility mandates the specific meal such as dinner that the residents must eat. In this type of setting the budget is easy to manage, because the number who will be eating in the dining room can be easily determine. When a meal plan system moves to a debit system or choice, forecasting becomes more challenging and additional food cost may be incurred. Since the decision of type of meal plan could significantly impact the operating budget and residents' satisfaction, the foodservice director and administrator will have to carefully assess the feasibility of each option.

The more frequently the chef and foodservice director interacted with the residents the higher the overall satisfaction ratings. For foodservice directors and administrators, this is an important aspect that needs to be addressed to improve overall customer satisfaction and perhaps

the dining experience. When relationships are developed, the customer is more likely to provide open and honest feedback at the time of the conversation and improve satisfaction.

Limitations and Future Study

A limitation of this study is it that satisfaction surveys were limited to CCRCs and retirement communities in the Midwest, thus results cannot be generalized to all regions of the United States. Within the Midwest region the study was limited to three states and within these states the number of facilities per state does not represent the entire state region. Further research should be conducted in the Midwest region and other regions within the United States to determine if results are similar. Another possible limitation is the length of survey. Physical abilities, such as poor eyesight and mental capacity such as memory, can create a limitation to the study. The foodservice directors recommended distributing the surveys before and after meal times, which could have limited the number of individuals who received the survey. Another limitation to the study is that the responses may have been completed based on the residents' regency experience instead of an overarching perception since moving to facility.

Further research can be conducted to determine what attributes influence residents to move into a CCRC. There are many articles discussing the perception of attributes that impact influences but no current research that validates these attributes. This type of research can be important for administrators to assure that the organizations focus on the right attributes that influence a resident to move into CCRCs and retirement communities.

Future studies should explore the impact of changing the meal plan option to allow more individual choices or a meal plan deductions system and residents' satisfaction. Previous studies have shown that the older population eats their largest meal in the evening and it would be interesting to determine if this trend will continue if meal plan choices are allowed.

References

Brandon, B., & Flury, E. (Jan 2009). Aging with choice: Coping with a changing marketplace. *Long-Term Living*. 58 (1), 15-18.

Buzalka, M. (2005). What does the future hold for CCRCs? *Food Management,* 40(9), 40.

Cavanaugh, B. B. (2003). Upscale dining drives sales at Hyatt Retirement Village-news-Hyatt at the glen. *Nation's Restaurant News*

Friedland, A. (2000, November). Senior dining, A revolution in the making? *Food Management,* 35(11), 44-48.

Holmes, S. (2006). Barriers to effective nutritional care for older adults. *Nursing Standard, 21*(3)

Howells, A. (2007). The impact of perceived quality on assisted living residents' satisfaction with their dining experience. Unpublished master dissertation, Kansas State University, Kansas.

Lee, K., Shanklin, C. W., & Johnson, D. E. (2003). Development of service quality measurement for foodservice in continuing care retirement communities. *Foodservice Research International*, pg. 1-21.

Seo, S., & Shanklin, C. W. (2005). Important food and service quality attributes of dining service in continuing care retirement communities. *Journal of Foodservice Business Research,* 8(4), 69-86

Appendix A - Permission Letter

實踐大學
Shih Chien University

July 8, 2010

I am writing this letter to grant permission to Heather Generali for use of the questionnaire that I developed for my dissertation entitled "Factors Affecting Satisfaction and Residents' Utilization of Foodservice In Assisted Living Facilities." in her study. I give Heather Generali permission to use this questionnaire and to revise it to specifically meet her research needs. Please properly cite the source in the thesis.

Sincerely,

Hui-chun Huang.

Hui-Chun Huang, Ph.D.
Assistant Professor
Dept. of Restaurant and Institutional Management
Shih Chien University, Taipei, Taiwan R.O.C.

Appendix B - Variables Used to Measure Satisfaction

Food Quality is measured by these items:

1. The food tastes good.
2. Foods are served at appropriate temperatures.
3. The quality of food is consistent each time it is served.
4. The food served is attractively presented.
5. The food is tender.
6. The food served is healthy.
7. The menu offers food items I enjoy.
8. A variety of menu items offered at each meal.

Quality Service is measured by these items:

1. The employee's appearances are neat.
2. The employees are well trained in service skills.
3. The servers are attentive to my needs.
4. The employees treat me with respect.
5. The employees use safe food handling practices.

Atmosphere is measured by these items:

1. The dining areas are accessible.
2. The dining areas are comfortable.
3. The atmosphere in the dining areas are inviting

Dining Venues are measured by these items:

1. I like having more than one option for dining at my retirement community.
2. The dining options provide opportunities for socialization.
3. The dining options provide sufficient variety.

Overall Satisfaction is measured by these items:

1. I am satisfied with the overall dining experience.
2. I will say positive things about the dining service to others.
3. I am satisfied with the service provided by wait staff or foodservice employee.
4. I am satisfied with the quality of food served.
5. I am satisfied with the atmosphere.

Appendix C - Final Survey Instrument

Evaluation of Service Quality, Food Quality, and Atmosphere

Instructions: Using the scale below, circle the number you feel best describes the food quality, service quality and atmosphere at (name of facility). The scale ranges from 1-strongly disagree to 5-strongly agree. Thank you for participating in this study.

1-Strongly Disagree	**2**- Disagree	**3**- Neutral	**4**-Agree	**5**-Strongly Agree

	SD	D	N	A	SA
The food tastes good	**1**	**2**	**3**	**4**	**5**
Foods are served at the appropriate temperatures.	**1**	**2**	**3**	**4**	**5**
The quality of food is consistent each time it is served.	**1**	**2**	**3**	**4**	**5**
The food served is attractively presented.	**1**	**2**	**3**	**4**	**5**
The food is tender.	**1**	**2**	**3**	**4**	**5**
The food served is healthy.	**1**	**2**	**3**	**4**	**5**
The menu offers food items that I enjoy.	**1**	**2**	**3**	**4**	**5**
A variety of menu items are offered at each meal.	**1**	**2**	**3**	**4**	**5**
Employing a chef will improve the quality of the food.	**1**	**2**	**3**	**4**	**5**
The employee appearance is neat.	**1**	**2**	**3**	**4**	**5**
The employees are well trained in service skills.	**1**	**2**	**3**	**4**	**5**
The servers are attentive to my needs.	**1**	**2**	**3**	**4**	**5**
The employees treat me with respect.	**1**	**2**	**3**	**4**	**5**
The employees use safe food handling practices.	**1**	**2**	**3**	**4**	**5**
The menu prices are appropriate for what is being served.	**1**	**2**	**3**	**4**	**5**
The dining areas are accessible.	**1**	**2**	**3**	**4**	**5**
The dining areas are comfortable.	**1**	**2**	**3**	**4**	**5**
The atmosphere in the dining areas is inviting.	**1**	**2**	**3**	**4**	**5**

	SD	D	N	A	SA
I like having more than one option for dining at my retirement community.	**1**	**2**	**3**	**4**	**5**
The dining options influenced my decision to move into the retirement community.	**1**	**2**	**3**	**4**	**5**
The dining options provide opportunities for socialization.	**1**	**2**	**3**	**4**	**5**
The dining options provide sufficient variety	**1**	**2**	**3**	**4**	**5**
I am satisfied with the overall dining experience.	**1**	**2**	**3**	**4**	**5**
I am satisfied with the service provided by wait staff or foodservice employee.	**1**	**2**	**3**	**4**	**5**
I am satisfied with the quality of the food served.	**1**	**2**	**3**	**4**	**5**
I am satisfied with the atmosphere.	**1**	**2**	**3**	**4**	**5**
The meal plan increases my frequency of eating in the dining areas.	**1**	**2**	**3**	**4**	**5**

Overall Perception of Foodservice

Using the scale below, circle the number you feel best describes the overall perception at (name of facility). The scale ranges from 1-extremely unlikely to 5-extremely likely.

1 – Extremely Unlikely

2 - Unlikely

3 - Neutral

4 - Likely

5 – Extremely Likely

	EL	U	N	L	EL
I will say positive things about the dining service to others.	**1**	**2**	**3**	**4**	**5**
I will invite my family to dine with me when they visit.	**1**	**2**	**3**	**4**	**5**
I will invite my friends to dine with me when they visit next.	**1**	**2**	**3**	**4**	**5**

Demographics

Directions – please check the most appropriate response.

1. What is your gender? _____ Male _____ Female

2. What is your marital status?
   _____ Single _____ Married _____ Widowed _____ Divorced

3. What year were you born? _____ Year

4. How long have you lived at (name of facility)?
   _____ Month _____ Year

5. What is your highest educational level?
   _____ Elementary School _____ High School _____ Associate Degree
   _____ Bachelor Degree _____ Master Degree _____ PhD _____ Other

6. How often do you eat in one or more of the dining options (restaurant, café, bistro, etc) (name of facility) per week?
   _____ Breakfast _____ Lunch _____Dinner
7. How frequently do your friends outside the facility dine with you?
   _____Never _____At least once per week
   _____At least once per month _____Occasionally

8. How frequently does your family outside the facility dine with you?
   _____Never _____At least once per week
   _____At least once per month _____Occasionally

9. How frequently do you interact or visit with the foodservice manager?
   _____Never _____At least once per week
   _____At least once per month _____Occasionally

10. How frequently do you interact with the chef?

_____Never _____At least once per week

_____At least once per month _____Occasionally

11. What do you like best about the **FOOD** served at Meadowlark Hills?

12. What do you like best about the **SERVICE** provided by Food Services at (name of facility)?

13. What suggestions do you have for the foodservice director or chef to improve the food served at (name of facility)?

THANK YOU FOR PARTICIPATING IN THIS STUDY!!

Appendix D - Questionnaire for Administrator and/or Foodservice Director

Questions for Administrator and/or Foodservice Director

1. Why did you change from an institutional to a hospitality environment?

2. When did you make the change to the hospitality environment?

3. Why did you choose to employ someone with a culinary background?

4. From you perspective what differences have you observed in customer satisfaction from residents and families?

5. What future changes would you like to make for (name of facility)?

6. To what extent are your dining venues opened to the public?

7. What additional types of dining options would you like to see at (name of facility)?

8. What is your perception of hospitality skills in dining services?

9. What does culinary mean to you?

Appendix E - Cover Letter to Residents

Date:

Dear Resident,

A research team from the Department of Hospitality Management and Dietetics at Kansas State University is conducting a survey to explore resident's satisfaction with the quality of food and services in (name of facility). The study will determine the level of satisfaction in Continued Care Retirement Communities and Retirement Communities that employs a foodservice manager with culinary training and expertise. As a resident in (name of facility), you have been selected to participate in this study. Results of this study will assist (name of facility) in improving overall satisfaction within the dining options. Results also will provide other Continued Care Retirement Communities and Retirement Communities information about factors influencing resident satisfaction.

Your participation in this study is voluntary and the information you provide will remain confidential. A summary of the responses and not individual responses will be provided to the administrator and food service manager at (name of facility). If you need assistance in filling out the questionnaire, please ask one of the researchers from Kansas State University or a family member to assist you. Return of the completed questionnaire indicates your willingness to participate in the study. You may keep this letter for your records; it does not need to be returned with the questionnaire. **PLEASE PLACE THE QUESTIONNAIRE IN THE BOX THAT IS PROVIDED IN (Place Location and Date).**

If you have any questions regarding the study, please contact Mrs. Heather Generali at (785) 313-0237 or heatherg@ksu.edu, or Dr. Carol W. Shanklin at (785)-532-7927 or shanklin@ksu.edu.

Sincerely,

Heather Generali RD, LD
Graduate Student

Carol W. Shanklin Ph.D., R.D.
Dean of Graduate, KSU Graduate School

For questions about your rights as a participant or the manner of the study is conducted, contact Dr. Rick Scheidt, Chair of Committee on Research Involving Human Subjects, (785) 532-3224, 1 Fairchild Hall, Kansas State University, Manhattan, KS 66506

Appendix F - Answers to Administrator and Foodservice Director Questionnaire

Answers to Administrator and Foodservice Director Questions

1. Why did you change from an institutional to a hospitality environment?

Administrator:

***Facility A**:* Evolution-from strict dietary to more food enjoyment. No diets unless under extreme. Better to have them eat a generali diet. Personal choice, offer suggestions. Diet available for anyone.

Facility E: Note been institutional. We have been upscale dining from the beginning 22 years old.

Foodservice Director:

***Facility A**:* COO decision. Was receiving constant issues and complaints

Facility B: Look at operating as a restaurant with a home. Common areas are still their home and how to balance home and restaurant.

Facility C: It has always been a hospitality environment. Our goal is to make the rest of your life to be the best of your life. Provide choices.

Facility D: It has always been a hospitality environment. Our goal is to make the rest of your life to be the best of your life. Provide choices.

Facility E: Never have been institutional. We might be institutional in regards to healthcare services.

Facility F: To add value to our service. Going from plop and serve to restaurant style. More comforting and gives them something to look forward too. It is about making it an occasion.

2. When did you make the change to the hospitality environment?

Administrator:

Facility A: At least 4 or 5 years ago- 46 year old facility.

Facility E: Always had hostess, adding a table busser.

Foodservice Director:

Facility A: Approximately 7 years ago when they hired me.

Facility B: Approximately 5 years ago.

Facility C: In 2009 went away from contract company that was in here for 25 years and hired hospitality background.

Facility D: Immanual purchased the retirement community 8 years ago.

Facility F: In Feb. 2007 changed Director of Dining from a healthcare focus to hospitality.

3. Why did you choose to employ someone with a culinary background?

Administrator:

Facility A: Want people who know how to prepare interesting and enjoyable food.

Facility E: Same answer as foodservice director for the facility.

Foodservice Director:

Facility A: Under management contract prior to 2003 and was not providing the culinary background needed.

Facility B: A corporate initiative with Morrison. Want to be a leader in the market segment. Economy has allowed more chef to be attracted to this segment.

Facility C: That is the trend. The resident's expect this and the title is what people value.

Facility D: To gain the skill and knowledge. Any type of dining needs to be chef driven. The difference is that it is about what the resident wants and not what you want.

Facility E: Strive for ever increasing bar of measure. Always have fine dining. Many special events to try out new things. Strive to refine services and systems to push our limits.

Facility F: We wanted to provide a higher quality with restaurant field experience. The focus was on restaurant style.

4. From you perspective what differences have you observed in customer satisfaction from residents and families?

Administrator:

Facility A: Not good satisfaction scores when contracted. Satisfaction up significantly with chefs.

Facility E: Since adding the Bistro, the count has doubled in the number of people who eat there.

Foodservice Director:

Facility A: Overall improvement in satisfaction scores.

Facility B: Overall steady increase in revenue. Increased catering activity which is an opportunity to make a statement to the community.

Facility C: Saw improvements from Nov. 2009 to Spring 2010 on selection of menu and temperature of foods. Receive feedback from food committee once a month. 50% of families are here on Sunday to eat with residents.

Facility D: Highest satisfaction ratings between all Immanuel communities due to skills brought to the community. Have strength in both back of house and front of house services. Developing relationships with residents and having people skills.

Facility E: Getting a lot more traffic in dining room. Residents are eating more than one meal per day and bringing in guests.

Facility F: Complaints have significantly declined since 2007. Before the complaints were focused around lack of care, hours of service and lack of service. No the complaints are now that the food is salty vs not too salty.

5. What future changes would you like to make for (name of facility)?

Administrator:

Facility A: Still too institutional with one meal per day. Would like to se a declining dollar model to offer more variety and choice along with more dining time. Older model, easier to project budget and costs with a one meal per day meal plan.

Facility E: Main socializing-upgrade customer service. Want it right. Looking at third venue with different feel (coffee shop, dance club, sports bar)

Foodservice Director:

Facility A: Change meal plan and move towards an ala carte menu plan. Currently on a 4 week menu cycle.

Facility B: Visualize a face lift with current dining room (built in 1970s). Quick service bistro environment (culture change initiative with resident to see this change). Grab and go. Retail mindset.

Facility C: All day dining from 7 a.m. to 7 p.m. We have a bistro in healthcare facility that is opened to whole community but does not count towards meal plan.

Facility D: Step up on service aspect. Fine tune servers with a training program for the servers. Connecting the outside community with the retirement community an example is the autistic connection network.

Facility E: As community expands and ages, mobility is becoming an issue. Possibility of opening a second dining room on other side of campus. Concern with breaking the community feeling with getting bigger.

Facility F: Keep bringing the quality up. Have restaurants self sustain 7 days a week. Want residents to dictate direction.

6. To what extent are your dining venues opened to the public?

Administrator:

Facility A: Recently opened a bistro-open to community at large as well as residents. Dining room is open to family and friends.

Facility E: Same answer as the foodservice director.

Foodservice Director:

Facility A: Bistro and Catering services are open to the public but not advertised yet.

Facility B: We don't advertise to public due to non profit status but open to

public coming if they want.

Facility C: Open to the public, but not advertised so hard for public to know we are here except word of mouth.

Facility D: You must be invited in by a resident. Provide caterings to church organizations but typically someone within the retirement community is part of these caterings.

Facility E: Bistro is open to the public but not advertised. Open to anyone on property. Dining room is for residents only.

Facility F: Completely open to the public, but no advertising.

7. What additional types of dining options would you like to see at (name of facility)?

Administrator:

Facility A: Main meal is evenings, would like to see lunch grow. More catering growth.

Facility E: Same answer as foodservice director.

Foodservice Director:

Facility A: Have at least one dining room and ultra formal dining room.

Facility B: Same answer as question #5.

Facility C: Add a bar and grill. Obtain a liquor license.

Facility D: A program that allows residents to choose between lunch and dinner like meal credits. Currently dinner is in package upon moving into facility.

Facility F: Sports Bar. Take the fine dining to the next level.

8. What is your perception of hospitality skills in dining services?

Administrator:

Facility A: Less rigidity with hospitality. More able to meet needs of customer.

Facility E: Deferred to Foodservice Director

Foodservice Director:

Facility A: Misleading being called dining services. The meal is the social time of the day.

Facility B: Basic good etiquette. Treat people as guest. The goal is to exceed expectations of the customers. Teach basic good service as you would in any restaurant.

Facility C: Getting to know your clients, so you know the needs. It is important to know the resident needs especially with the population living here. Treating the customer with respect and remembering the little things like names.

Facility D: Make every resident feel that it is their home. Bending over backwards to do the little things. Little things make a huge difference. Being flexible. Accommodate specific diets as requested.

Facility E: Service is what distinguishes hospitality. Making people feel welcomed, pampered, openness and comforted.

Facility F: Friendly, kind. Taking care of the person serving.

9. What does culinary mean to you?

Administrator:

Facility A: New cooking skills and looking at the aesthesis of the dining area.

Facility E: As management, menus for the week to tempt residents with something new. Intent to attempt residents engage and eating beautifully upscale.

Foodservice Director:

Facility A: Art of food. Not just cooking, how presented, building the menu.

Facility B: Science of preparing food in a quality fashion so you deliver it in a wholesome fashion and meet the balanced need of the community.

Facility C: Knowledge to prepare and present food in a safe environment.

Facility D: Being able to take a basket of ingredients and make something good the resident or guest would like. Not a technique but a way to put it together and make the people happy.

Facility E: Residents want more upscale. Always off staples and comfort foods. Strive to find ways to present food differently. Try to find ways to make it not boring for the residents.

Facility F: Art of Food and Service. It is the whole package, taste, atmosphere, quality, and presentation.