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COVID-19, Visitation and Spiritual Care: Responding to the Silent Suffering of the Isolated in Times of Crisis

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**COVID-19, VISITATION AND SPIRITUAL CARE: RESPONDING TO THE
SILENT SUFFERING OF THE ISOLATED IN TIMES OF CRISIS**

Lucia A. Silecchia*

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INTRODUCTION

COVID-19 has taken a terrible toll physically, emotionally, socially, and economically since it first grabbed headlines in early 2020. The years ahead will bring time to reflect on the many decisions made and decrees issued in attempts to stop its spread.¹ There will be opportunities to assess the impact of these measures as many unintended consequences and harmful side effects come to light.²

¹Indeed, the reflection seems to be well underway. *See generally* U.S. GOV'T ACCOUNTABILITY OFF., GAO-22-105133, COVID-19 IN NURSING HOMES: CMS NEEDS TO CONTINUE TO STRENGTHEN OVERSIGHT OF INFECTION PREVENTION AND CONTROL (2022) [hereinafter GAO-22-105133].

²In addition, as policymakers continue to fear the impact of COVID-19 variants, there is still the possibility that some version of these actions may be repeated.

One set of decisions forced dramatic, near-total isolation for vulnerable persons. Those living in nursing homes, assisted living communities, and other congregate settings were deprived of visitation, companionship, and spiritual support for months. For purposes of this article, these facilities will be referred to collectively as “congregate residential settings.”³

Although this isolation was initially imposed to protect residents and staff from COVID-19 infection, the collateral consequences were devastating.⁴ While there were limited exceptions for “compassionate care,”⁵ for all too many, the months of COVID-19 were dangerously lonely. Emerging evidence correlates this deprivation to an excess number of non-COVID-19 deaths and significant physical and cognitive decline, with a particularly

³ Although nursing homes, group homes, and assisted living communities have significant differences, serve different communities, and are subject to different regulations, these distinctions are generally not central to this article. The sources of regulatory authority were different, and this affected the contours and scope of particular restrictions. However, the interests of residents were consistent in all these settings. Because hospitals are—for reasons to be discussed later—different in some meaningful ways, hospitals will not be the primary focus of this analysis. Although nursing homes receive more attention, this article attempts to consider the broad range of congregate residential settings for vulnerable people because:

Nursing homes are not the only settings in which people with disabilities and older adults have faced a heightened risk of COVID-19 infection or death. Similar risk factors—such as high occupancy density resulting in social distancing challenges or close contact with staff who provide self-care assistance to numerous people each day—exist in a range of other congregate care settings.

See Larisa Antonisse, Note, *Strengthening the Right to Medicaid Home and Community-Based Services in the Post-COVID Era*, 121 COLUM. L. REV. 1801, 1809 (2021) (discussing the spread of COVID-19 through congregate care settings); see also *id.* at 1811 (critiquing the media for “paying less attention to equally severe outbreaks in other types of settings that primarily serve people with disabilities”); *id.* (critiquing the way government actions “intended to address the COVID-19 crisis in long-term care facilities targeted nursing homes alone, ignoring the similar and equally pressing crises in other facilities serving people with disabilities”).

⁴ For a thoughtful overview of this tension, see generally Marina Saldaris, *The Dichotomy of Social Isolation in a Global Pandemic When the Power to Protect Actually Harms*, 30 ANNALS HEALTH L. ADVANCE DIRECTIVE 313 (2020). In addition, in Kathy L. Cerminara et al., *Using Therapeutic Jurisprudence to Improve Nursing Home Regulation During Future Pandemics*, 46 NOVA L. REV. 330 (2022), the authors’ perceptive analysis of the collateral harm caused by isolation in time of pandemic offers a sobering insight. While they focus in particular on Florida, the medical commentary makes a compelling case that a strategy focused solely on COVID-19 infections missed other serious harms.

⁵ See CTRS. FOR MEDICARE & MEDICAID SERVS., NURSING HOME VISITATION—COVID-19 (2020), <https://www.cms.gov/files/document/qso-20-39-nh.pdf> [hereinafter CMS 9/17/20 MEMO] (emphasis added).

devastating impact on those living with dementia.⁶ Moreover, this enforced isolation raises profound questions about fundamental human dignity and basic human rights.⁷ Congregate residential settings are places that vulnerable people call home. To deprive individuals of companionship in their own homes—communal though they may be—raises significant concerns, especially if that deprivation endures for extended periods of time.

This article will begin with a brief overview of the ways in which the freedom of those in congregate residential settings to have visitation was curtailed. While there were often good intentions behind these restrictions, and some safeguards were and may again become necessary, the article will argue that, over time, these measures became excessive when balanced against the harm they caused.

After reviewing this general landscape, the article will focus on the harm visitation restrictions did to the physical, emotional, and spiritual well-being of those living in congregate residential settings. It will argue that access to companionship is critically important with respect to both:

- *General* visitation of family and friends; and
- *Specific* visitation for the purpose of spiritual care.⁸

⁶The intended and unintended impact of COVID-19-motivated social restrictions is explored more fully in Aurora Curelaru et al., *Social Isolation in Dementia: The Effects of COVID-19*, 17 J. FOR NURSE PRACTITIONERS 950, 950–51 (2021) (discussing how loneliness affects dementia). See AIDA SUÁREZ-GONZÁLEZ ET AL., IMPACT AND MORTALITY OF COVID-19 ON PEOPLE LIVING WITH DEMENTIA: CROSS-COUNTRY REPORT 12 (Int'l Long Term Care Pol'y Network, 2020) [hereinafter SUÁREZ-GONZÁLEZ ET AL., IMPACT OF COVID-19 ON PEOPLE LIVING WITH DEMENTIA] (exploring impact of COVID-19 on those living with dementia); William Wan, *Pandemic Isolation Has Killed Thousands of Alzheimer's Patients While Families Watch from Afar*, WASH. POST (Sept. 16, 2020) [hereinafter Wan, *Pandemic Isolation*], <https://www.washingtonpost.com/health/2020/09/16/coronavirus-dementia-alzheimers-deaths/> (chronicling impact of COVID-19 visitation restrictions on Alzheimer's patients and reporting that between March and September of 2020 there were “13,200 more U.S. deaths caused by dementia than expected, compared with previous years”); and Aida Suárez-González et al., *The Effect of COVID-19 Isolation Measures on the Cognition and Mental Health of People Living with Dementia: A Rapid Systematic Review of One Year of Quantitative Evidence*, ECLINICALMEDICINE, Sept. 20, 2021, at 2 [hereinafter Suárez-González et al., *The Effect of COVID-19*] (reviewing impact of imposed isolation during COVID-19 on those living with dementia).

⁷See generally U.N. SUSTAINABLE DEV. GRP., POLICY BRIEF: THE IMPACT OF COVID-19 ON OLDER PERSONS (2020) [hereinafter U.N. POLICY BRIEF], <https://unsdg.un.org/sites/default/files/2020-05/Policy-Brief-The-Impact-of-COVID-19-on-Older-Persons.pdf> (addressing, broadly, the impact of COVID-19 on the basic rights of elders).

⁸Indeed, particular focus will be directed here as this aspect of isolation has largely been ignored. Restrictions limited residents' access to clergy, sacraments, worship services, and other

The article will conclude with a comprehensive proposal for ensuring that access to *both* types of visitations is better protected in the future. To do this, it will review initiatives already considered or adopted and propose a policy that respects the need to protect against both the harms of a pandemic and the harms of isolation.

I. OVERVIEW OF THE PROBLEM: RESTRICTIONS ON VISITATION

The arrival of COVID-19 launched an extraordinary period in modern history, with a devastating medical toll, and economic, social, political, and emotional impacts on nearly every facet of day-to-day life.⁹ In addition, many responses to COVID-19 after a National Emergency was declared on March 13, 2020,¹⁰ raised significant legal issues.¹¹ Many mandates drastically curtailed everyday activities, and many were imposed via emergency measures and executive orders, rather than the slower deliberative legislative process.¹² Very quickly, “governors and local officials across the country

spiritual care during the COVID-19 era. This has not received much attention—although, paradoxically, in the litigation over COVID-19 restrictions in the “outside” world, the impact of such restrictions in the context of religious free exercise was the subject of significant attention and litigation. *See* Press Release, U.S. Dep’t of Health and Hum. Servs., *OCR Resolves Religious Discrimination Complaints after Maryland and Virginia Hospitals Ensure Patients Can Receive Safe Religious Visitations During COVID-19* (Oct. 20, 2020), <https://public3.pagefreezer.com/content/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2020/10/20/ocr-resolves-religious-discrimination-complaints-after-maryland-and-virginia-hospitals-ensure.html>.

⁹See Lawrence O. Gostin et al., *Responding to COVID-19: How to Navigate a Public Health Emergency Legally and Ethically*, HASTINGS CTR. REP., March–April 2020, at 8, 8 (observing that “[f]ew novel or emerging infectious diseases have posed such vital ethical challenges so quickly and dramatically as the novel coronavirus”); and Tiffany C. Li, *Post-Pandemic Privacy Law*, 70 AM. U. L. REV. 1681, 1681 (2021) (observing that COVID-19 “altered how we live our lives in just about every way imaginable”).

¹⁰Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, 85 Fed. Reg. 15337, 15337 (Mar. 18, 2020).

¹¹For a bibliography of commentary on the legal issues raised by COVID-19, see generally JONATHAN G. ODOM, *COVID-19 AND THE LAW: A COMPILATION OF LEGAL RESOURCES* (Mar. 11, 2021 ed.), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3588225.

¹²The unusual, emergency nature of the restrictions is explored in Wendy E. Parmet, *The COVID Cases: A Preliminary Assessment of Judicial Review of Public Health Powers During a Partisan and Polarized Pandemic*, 57 SANDIEGOL. REV. 999 (2020). *See also* Josh Blackman, *The “Essential” Free Exercise Clause*, 44 HARV. J.L. & PUB. POL’Y 637, 649 (observing that, throughout COVID, “governors relied on emergency powers to regulate every facet of human interaction”). For a listing of the numerous executive orders issued in response to COVID-19, *see*

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used their emergency powers to impose a range of social distancing orders . . . shuttering businesses, restricting religious services, requiring the wearing of masks, and banning nonessential medical services, all in an effort to ‘flatten the curve.’”¹³ This often seemed necessary, and it responded to the rapid unfolding of events both unpredictable and deadly.

It was clear from the start that COVID-19 took its greatest toll on older persons¹⁴ and those with other underlying medical conditions¹⁵—groups with significant overlap. It was particularly deadly in congregate residential settings¹⁶ such as nursing homes,¹⁷ assisted living communities, group homes, and other communal living arrangements for the elderly and persons

Covid-19 Resources for State Leaders, Executive Orders, COUNCIL OF STATE GOV'TS, <https://web.csg.org/covid19/executive-orders/>.

¹³Parmet, *supra* note 12, at 1000–01.

¹⁴This disproportionate impact on elders was clear from the start of the pandemic. U.N. POLICY BRIEF, *supra* note 7, at 2 (noting that with COVID-19, “fatality rates for those over 80 years of age is five times the global average”); U.S. GOV'T ACCOUNTABILITY OFF., GAO-21-402T, COVID-19 IN NURSING HOMES: HHS HAS TAKEN STEPS IN RESPONSE TO PANDEMIC, BUT SEVERAL GAO RECOMMENDATIONS HAVE NOT BEEN IMPLEMENTED 1 (2021) [hereinafter GAO-21-402T] (“While the nation’s 1.4 million nursing home residents are a small share of the total U.S. population (less than 1 percent), they comprise nearly 30 percent of COVID-19 deaths reported by [the CDC].”).

¹⁵U.N. POLICY BRIEF, *supra* note 7, at 4.

¹⁶For one of the most comprehensive overviews of this issue to date, see generally Brendan Williams, *Left for Dead: Nursing Home Care Amidst the COVID-19 Pandemic*, 24 QUINNIPIAC HEALTH L.J. 29 (2020). In addition, in the spring of 2020—as COVID-19 was raging—the Centers for Medicare and Medicaid Services contracted with the MITRE Corporation to convene experts to prepare a report on the impact of COVID-19 on nursing homes. Their comprehensive analysis was published in September 2020 as CORONAVIRUS COMMISSION FOR SAFETY AND QUALITY IN NURSING HOMES, COMMISSION FINAL REPORT (2020), <https://www.cms.gov/files/document/covid-final-nh-commission-report.pdf> [hereinafter COMMISSION FINAL REPORT].

¹⁷See The White House, *Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation’s Nursing Homes* (Feb. 28, 2022), <https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/> [hereinafter *White House Fact Sheet*] (“[M]ore than 200,000 residents and staff in nursing homes have died from COVID-19—nearly a quarter of all COVID-19 deaths in the United States.”). Nursing homes are more heavily regulated by the federal government, in contrast to assisted living communities and other residential settings that tend to be the focus of state-level regulation. In the United States, there are “more than 15,000 nursing homes that care for approximately 1.2 million residents. Annual spending in 2018 on nursing homes was approximately \$170 billion, with Medicare spending approximately \$38 billion and Medicaid spending approximately \$50 billion.” COMMISSION FINAL REPORT, *supra* note 16, at 6 (citations omitted).

with disabilities.¹⁸ The impact was devastating here,¹⁹ due to such inherent factors as necessary, frequent physical contact with staff, close living quarters and the vulnerabilities of age and medical condition often shared by

¹⁸For a discussion of the impact of COVID-19 on persons living with disabilities, see generally Laura Guidry-Grimes et al., *Disability Rights as a Necessary Framework for Crisis Standards of Care and the Future of Health Care*, HASTINGS CTR. REP., May–June 2020, at 28.

¹⁹In the initial stages of the pandemic, for example, it was reported that “[a]lthough less than 0.5% of the total US population . . . live in nursing homes, nursing home residents have accounted for approximately 25% of the documented deaths due to COVID-19.” David C. Grabowski & Vincent Mor, *Nursing Home Care in Crisis in the Wake of COVID-19*, 324 J. AM. MED. ASS’N 23, 23 (2020). See also Sam F. Halabi, *The Legal Structure of COVID-19 Nursing Home Deaths*, 11 WAKE FOREST J.L. & POL’Y 569, 572–74 (2021) (reviewing statistics of the overwhelmingly high proportion of COVID-19 cases in nursing homes residents in contrast to the general population); U.N. POLICY BRIEF, *supra* note 7, at 6 (“A particularly horrifying picture has emerged regarding the impact of COVID-19 on older persons in long-term care facilities.”); *id.* at 7 (“While the situation of older persons in lower-resource environments may be different, similar or even worse mortality rates may be expected where high concentrations of older persons are living in close quarters.”); Adam Taylor, *As Covid-19 Cases Surge, Global Study Paints Grim Picture for Elder-Care Homes*, WASH. POST (Oct. 16, 2020, 11:58 AM), <https://www.washingtonpost.com/world/2020/10/15/long-term-elder-care-coronavirus-nursing-homes-research-lessons/> (observing that, in the first months of COVID-19, “[a]cross 26 countries, elder-care home residents have accounted for an average of 47 percent of recorded coronavirus deaths”); Matthew Giovenco, Note, *Lessons the Long-Term Care Industry Can Learn from the COVID-19 Pandemic*, 51 STETSON L. REV. 123 (2021) (exploring particular dangers that COVID-19 raised in the nursing home setting); and Antonisse, *supra* note 3, at 1801 (“The COVID-19 pandemic has laid bare the severe public health danger that institutional and congregate care settings pose to people with disabilities, older adults, and the care professionals who work in those settings.”).

residents.²⁰ Indeed, nursing homes were “at the epicenter”²¹ of the COVID-19 outbreak, particularly in the early months of the virus’s spread.²² Among

²⁰ See, e.g., Hugh M. Lee, *Nursing Home Liability for COVID-19 Transmission and Death: Proposed and Enacted Federal and State Responses to the Pandemic*, ELDER L. ADVISORY, Sept. 2020, 354 Elder Law Advisory NL 1 (“The close proximity of residents, the shared communal environment, the treatment of multiple patients by staff members, the frequent exposure to family members from outside the facility, and the high-risk nature of the resident population all combine to make the nursing home an ideal environment for spreading COVID-19.”); Halabi, *supra* note 19, at 603 (“Nursing home residents share the same air, food, water, caregivers, and medical care.”); Mario Tagliabue et al., *Preventing COVID-19 in Assisted Living Facilities: An Impossible Task Pending Vaccination Roll Out*, PREVENTIVE MED. REPS., Sept. 2021, at 1, 6 (2021) (“Long-term care residents are particularly vulnerable to COVID-19 This is due to the frailty of this population . . . and the fact that the closed environment in which they live can favor the spread of infection.”); Nicola Veronese & Mario Barbagallo, *Specific Approaches to Patients Affected by Dementia and COVID-19 in Nursing Homes: The Role of the Geriatrician*, AGEING RSCH. REVS., Aug 2021, at 1, 1 (2021) (“[N]ursing homes commonly include people that are particularly frail. Moreover, even if less than 10 % of all COVID-19 cases are observed in nursing home[s], nursing home residents accounted for more than one third of all the deaths recorded.”); Tia Powell et al., *Older Adults and Covid-19: The Most Vulnerable, the Hardest Hit*, HASTINGS CTR. REP., May–June 2020, at 61, 61 (“Nursing homes are among the riskiest settings for Covid-19; they care for the most vulnerable, frail older adults with comorbidities.”); Guidry-Grimes, *supra* note 18, at 29 (noting that COVID-19 “has had a devastating impact on congregate care settings like nursing homes, state institutions, psychiatric hospitals, and group homes”); David English, *So Many Have Died: COVID-19 in America’s Nursing Homes*, PROB. & PROP. MAG., Jan.–Feb. 2021, at 12 (reviewing COVID-19 crisis in nursing homes); Farah Stockman et al., *They’re Death Pits’: Virus Claims at Least 7,000 Lives in U.S. Nursing Homes*, N.Y. TIMES (Apr. 17, 2020), <https://www.nytimes.com/2020/04/17/us/coronavirus-nursing-homes.html> (noting that COVID-19 is “more deadly to aging, immune-compromised people, and small, confined settings like nursing homes, where workers frequently move from one room to the next, are particularly vulnerable to spreading infection”); Beth A. Norton, *COVID-19 Liability in Long-Term Care: A Tidal Wave or a Trickle of Litigation in Virginia?*, VA. LAW., Feb. 2021, at 14, 14 (“[I]n terms of COVID deaths, no other community in the U.S. has suffered like the residents of long-term care . . . facilities”); Williams, *supra* note 16, at 32 (theorizing that the devastating impact of COVID-19 on nursing homes was a result of intertwined factors such as “government underfunding; the elderly demographics of the resident population that put residents at heightened risk; and a longstanding marginalization of long-term care—as compared to other health care sectors—that became especially visible during the pandemic”); Suzy Khimm, *America Now Knows That Nursing Homes Are Broken. Does Anyone Care Enough to Fix Them?*, NBC NEWS (Mar. 7, 2021, 3:30 AM), <https://www.nbcnews.com/politics/politics-news/america-now-knows-nursing-homes-are-broken-does-anyone-care-n1259766> (“The pandemic turned nursing homes into a death trap”); *id.* (“Nursing homes, by their nature, are ideal breeding grounds for Covid-19”); Ruslan Leontjevas et al., *Challenging Behavior of Nursing Home Residents During COVID-19 Measures in the Netherlands*, 25 AGING & MENTAL HEALTH 1314, 1314 (2021) (citing “sharing of physical space and sanitary with others, daily procedures in residents like the use of catheters and incontinence material, and inability of residents to uphold the preventive measures because of

the early decisions enacted to safeguard vulnerable residents were swift, severe restrictions on visitors.²³

A. Hospital Restrictions

A good deal of public attention was focused on visitor restrictions in the hospital setting. Hospitals passed extremely strict limitations, largely because they were often caring for many COVID-19-positive patients, lacked personal protective equipment, and were understaffed in ways that would counsel against inviting additional infection risk.²⁴ Heartbreaking stories emerged of many who died alone,²⁵ without either family or sacred religious rituals in their final hours:

cognitive impairment”); GAO-22-105133, *supra* note 1, at 7 (“Nursing home residents are at increased risk because older adults and those with underlying health conditions have a high mortality rate when infected with the virus [T]he congregate nature of nursing homes—with staff caring for multiple residents and residents sharing rooms and other communal spaces—can increase the risk that COVID-19 will enter the home and easily spread.”); Cerminara et al., *supra* note 4, at 340–41 (“The attributes of the disease itself, the susceptibility of the population, and the close-quartered structure of nursing-home-living all produced what has been hailed the ‘perfect storm.’”); and Abigail Abrams, *COVID-19 Exposed the Faults in America’s Elder Care System. This is Our Best Shot to Fix Them*, TIME (June 15, 2021, 7:00 AM), <https://time.com/6071582/elder-care-after-covid-19/> (“Nursing homes and other group facilities are inherently petri dishes for pathogens. People with frail health frequently share rooms and rely on workers to help them bathe, eat and get out of bed.”).

²¹Marco Cassone & Lona Mody, *Measuring the Outsized Impact of COVID-19 in the Evolving Setting of Aged Care Facilities*, ECLINICALMEDICINE, Apr. 2021, at 1, 1, <https://www.thelancet.com/action/showPdf?pii=S2589-5370%2821%2900105-X>.

²²For updated statistics on COVID-19 deaths and cases, see Ctrs. for Medicare & Medicaid Servs., *COVID-19 Nursing Home Data*, DATA.CMS.GOV (Sept. 4, 2022), <https://data.cms.gov/covid-19/covid-19-nursing-home-data>; *COVID Data Tracker*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 4, 2022), <https://covid.cdc.gov/covid-data-tracker/#datatracker-home>; and *COVID-19: Understanding Risk*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 11, 2022), <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index.html>.

²³In addition, COVID-19 outbreaks in nursing homes posed a risk to the staff of such homes as well. See English, *supra* note 20, at 14 (noting that CMS reports that as of May 31, 2020—still early in the pandemic—“over 400 staff had died”).

²⁴See William Wan, *America is Running Short on Masks, Gowns and Gloves. Again.*, WASH. POST (July 8, 2020, 8:00 PM), <https://www.washingtonpost.com/health/2020/07/08/ppe-shortage-masks-gloves-gowns/>.

²⁵For a poignant account of the importance of company at death, see generally Ken Budd, *On the Obligation to Prevent People from Dying Alone*, WASH. POST (Dec. 8, 2021), <https://www.washingtonpost.com/magazine/2021/12/08/obligation-prevent-people-dying-alone/>.

There have been profound images . . . of patients dying with no family present in the ICU, with desperate and compassionate attempts by clinicians to respect the sacred time of dying. Rabbis, imams, priests, and other spiritual care providers are frantically sought to offer prayers, blessings, pardons, and chants. . . . [F]or many, spiritual care is absent, given the very real limitations and demands. The masked face of a young nurse holding her own gloved cell phone as a faith leader remotely offers a blessing to a dying patient from afar is a frequent image that offers both comfort and angst.²⁶

There was impassioned critique of the impact this had on both hospital patients and their anguished loved ones.²⁷ Some policies changed to allow extremely limited visitation in delivery rooms and at the end of life.²⁸ However, there were very few other exceptions, even though studies illustrate the negative impact of such limits on postoperative recovery of hospitalized, non-COVID-19 patients.²⁹

²⁶ Betty R. Ferrell et al., *The Urgency of Spiritual Care: COVID-19 and the Critical Need for Whole-Person Palliation*, J. PAIN & SYMPTOM MGMT., Sept. 2020, at e7, e8.

²⁷ See, e.g., John Whyte, *No Visitors Allowed: We Need Humane Hospital Policy During COVID-19*, THE HILL (Apr. 2, 2020, 5:00 PM), <https://thehill.com/opinion/healthcare/490828-no-visitors-allowed-we-need-humane-hospital-policy-during-covid-19/>; Glenn K. Wakam et al., *Not Dying Alone — Modern Compassionate Care in the Covid-19 Pandemic*, NEW ENG. J. MED., June 11, 2020, at e88(1), e88(1); Cara L. Wallace et al., *Grief During the COVID-19 Pandemic: Considerations for Palliative Care Providers*, J. PAIN & SYMPTOM MGMT., July 2020, at e70, e70 (noting that “[s]ocial media feeds are full of devastating stories—families denied opportunities to say goodbye before a death, or loved ones saying goodbye over phone/video, uncertain whether each communication is the last”); and Maayan Sudai, *Not Dying Alone: The Need to Democratize Hospital Visitation Policies During Covid-19*, 29 MED. L. REV. 613 (2021) (discussing impact of “no visitation” policies in hospital settings during COVID-19).

²⁸ See Richard E. Leiter & Samantha Gelfand, *Even During a Pandemic, Hospitals Must Make Family Visits and Communication the Standard of Care*, STAT (Jan. 9, 2021), <https://www.statnews.com/2021/01/09/even-during-a-pandemic-hospitals-must-make-family-visits-and-communication-the-standard-of-care/>.

²⁹ See Ryan D. Zeh et al., *Impact of Visitor Restriction Rules on the Postoperative Experience of COVID-19 Negative Patients Undergoing Surgery*, 168 SURGERY 770 (2020) (reporting on the results of a study of patient reactions to the recovery process before and after visitor restrictions were imposed in March 2020, and concluding, among other things, that “feelings of isolation and loneliness were common among those without visitors” *id.* at 772; “patients lacking visitors were more likely to be dissatisfied with their overall hospital experience,” *id.* at 773; “lack of visitors adversely affected patients’ psychosocial well-being,” *id.*; “patients without visitors were less likely

Visitor restrictions in hospitals are beyond the scope of this article. Nevertheless, high-profile hospital restrictions garnered much attention and provided an important backdrop for public awareness of the restrictions in congregate residential settings.

B. Congregate Residential Setting Restrictions

There are several reasons why the deprivation of visitors—generally and for spiritual care—in the congregate residential setting was particularly devastating, even vis-à-vis hospitals:

- Those in congregate residential settings live there on a long-term basis, while those in hospitals tend to have far shorter stays. As the days, weeks, and months wore on, the impact of isolation was, temporally, longer for those in congregate residential settings.
- By most accounts, hospitals received greater attention and priority in the early days of the COVID emergency.³⁰ As noted in one report, “care homes were left in the shadows for some time during the pandemic, with by far the main bulk of resources being deployed to health care/hospital systems.”³¹

to have their preferences adequately addressed upon discharge,” *id.*; and noting that patients in cohorts with and without visitors “reported the importance of visitors in providing psychosocial support during the hospital stay,” *id.* at 775). This has also been discussed in the context of pediatric care. See generally Karen Goldschmidt & Cheryl Mele, *Disruption of Patient and Family Centered Care Through the COVID-19 Pandemic*, 58 J. PEDIATRIC NURSING 102 (2021).

³⁰See Williams, *supra* note 16, at 39 (noting that COVID-19 “further revealed the ‘most favored nation’ status of hospitals relative to nursing homes, even when most deaths were occurring in long-term care facilities”); *id.* (“[c]omparatively little positive public attention has been paid to staff at long-term-care facilities.”); and COMMISSION FINAL REPORT, *supra* note 16, at 11 (“Often, nursing homes may be deemed lower-priority facilities for assistance from government sources in comparison to acute care settings.”). This prioritization was by no means limited to the United States. For an international perspective on the prioritization of hospitals and neglect of long-term care facilities, see generally Matina Stevis-Gridneff et al., *When Covid-19 Hit, Many Elderly Were Left to Die*, N.Y. TIMES (Dec. 30, 2020), <https://www.nytimes.com/2020/08/08/world/europe/coronavirus-nursing-homes-elderly.html>.

³¹SUÁREZ-GONZÁLEZ ET AL., IMPACT OF COVID-19 ON PEOPLE LIVING WITH DEMENTIA, *supra* note 6, at 27; see also Powell et al., *supra* note 20, at 61–62 (“Most nursing homes lack the financial resources and clout of acute care facilities. These disadvantages meant that, in the scramble for access to testing and personal protective equipment, nursing homes were not given priority. . . . Without either the infrastructure or emergency support from governmental agencies, nursing homes were unable to withstand the onslaught of cases.”); Charles C. Camosy, *Yes, We Rationed Care at the Height of the Pandemic and the Elderly Paid the Price*, RELIGION NEWS SERV. (June 18, 2020), <https://religionnews.com/2020/06/18/yes-we-rationed-care-at-the-height-of-the-pandemic-and-the->

- Those in congregate residential settings are in their own homes. There may well be greater expectations of autonomy, privacy, and freedom in this context compared to hospital settings.³²

Certainly, decisions to limit visitors had an understandable rationale.³³ There was deep fear surrounding a disease about which little was known, from which vulnerable people were at high risk, for which testing was lacking, and for which woefully inadequate planning on all levels—federal, state, local and institutional—meant a dearth of personal protective equipment for residents, essential staff, and visitors.³⁴

elderly-paid-the-price/ (“Another way that we rationed limited resources was by deciding which institutions would get limited supplies of personal protective equipment and tests. Acute care facilities like hospitals and clinics got them. Nursing homes did not.”); Charles C. Camosy, *What’s Behind the Nursing Home Horror*, N.Y. TIMES (May 17, 2020), <https://www.nytimes.com/2020/05/17/opinion/nursing-home-coronavirus.html> (“Personal protective equipment, special training and extra staff went almost exclusively to our critical care facilities. Nursing homes got virtually nothing.”); and Stockman et al., *supra* note 20 (noting the lower priority of nursing homes and other residential settings vis-à-vis hospitals with respect to protective gear, testing, and other key resources for responding to COVID-19).

³²This distinction is one that often is overlooked, as those in congregate residential settings are often viewed from a medical perspective—even though they are receiving care in what has become their home. This was, however, recognized in COMMISSION FINAL REPORT, *supra* note 16, at 13, which acknowledged, “the nursing home is many residents’ home—not a temporary care setting.”

³³See Halabi, *supra* note 20, at 602–03 (“Pathogens almost always enter nursing homes from outside—caregivers, visitors, practitioners—and therefore once presented with the possibility of an easily transmitted, virulent pathogen, facilities should be able to identify resources and personnel needed, lock down, allow only essential entrants, and aggressively test those essential personnel.”). Haziq noted that in the analogous hospital context:

From an infection control perspective, there are certainly valid reasons to limit visitation. Even with temperature screenings, any movement into and out of a hospital poses a risk of transmitting disease. . . . Early in the COVID-19 pandemic, limitations in testing capacity, personal protective equipment (PPE), and staffing made it challenging to ensure safe visitation. In many cases, it was almost impossible to mitigate the transmission risk that visitors posed.

Haziq Siddiqi, *To Suffer Alone: Hospital Visitation Policies During COVID-19*, 15 J. HOSP. MED. 694, 694 (Nov. 2020). See also Cassone & Mody, *supra* note 21, at 1 (reporting that “more than 40% of outbreaks originated from a healthcare worker or visitor”); and Tagliabue et al., *supra* note 20, at 6 (“[O]nce SARS-CoV-2 infection has entered a long-term care facility, it can lead to high attack rates among residents, staff members and visitors.” (citation omitted)).

³⁴See, e.g., Jiwoon Kong, Note, *Safeguarding the Free Exercise of Religion During the Covid-19 Pandemic*, 89 FORDHAM L. REV. 1589, 1593 (2021) (observing that in March 2020, when many of the restrictions were first enacted, “the virus was still relatively unknown, with scientific and political opinion sharply divided on how best to combat the virus; medical organizations debated

Thus, the Center for Medicare and Medicaid Services (“CMS”), Centers for Disease Control (“CDC”), state and local governments, and individual institutions determined that an efficient, effective way to reduce COVID-19 transmission was, essentially, to lock down and allow visitors only in strictly limited situations.³⁵ These restrictions, it was reasoned, would not merely protect residents from the possibility that their own visitors might infect them. Infection could also spread to other residents³⁶ and to an already overburdened, limited staff.³⁷ From an infection-prevention perspective, the benefits of lockdown seemed clear.³⁸

the effectiveness of social distancing protocols and personal protective equipment”); Michael Levere et al., *The Adverse Effects of the COVID-19 Pandemic on Nursing Home Resident Well-Being*, 22 J. AM. MED. DIRS. ASS’N 948, 949 (2021) (“Policies that restricted visitors and limited resident movement and social interactions likely prevented the virus from spreading further and bought nursing homes and states time to procure sufficient PPE and increase testing capacity.”); and GAO-22-105133, *supra* note 1, at 13 (noting that in the early stages of the pandemic “nursing homes faced multiple complex challenges, including: understanding a novel virus, inability to test to detect asymptomatic infected individuals, variable personal protective equipment supply access, staffing shortages . . . , increasing cases across the country with few effective treatments available, and no vaccine availability”).

³⁵This was consistent with the view that, from an infection control perspective, “[t]he most effective way to prevent the spread of the virus is to limit the frequency and duration of close physical contact between an infected individual and an uninfected individual.” COMMISSION FINAL REPORT, *supra* note 16, at 8.

³⁶See Nili Karako-Eyal, *“Love is Distance”: Is That So? Lockdown Strategies, Medically Vulnerable People, and Relational Ethics*, 35 BYU J. PUB. L. 151 (2021) (exploring the difficulty in balancing the autonomous decision-making of residents who want to risk infection to see loved ones and other residents who do not share this choice).

³⁷See, e.g., English, *supra* note 20, at 15 (observing that “[s]taff who have been quarantined are not easy to replace, and some staff members are reluctant to place their lives at daily risk of infection”); and COMMISSION FINAL REPORT, *supra* note 16, at 48 (“Deaths among nursing home staff during the pandemic illustrate how dangerous these jobs have become.”).

³⁸As Bethell and others explained:

Coronavirus (COVID-19) has taken a disproportionate toll on people living in long-term care (LTC) homes. To protect LTC residents from COVID-19 infection, infection control measures have included prohibiting visitors and restricting activities and interactions with other residents and staff in the home. Although these measures may have reduced risk of infection, they have also presented their own health risks through the devastating impact on resident’s social connection.

Jennifer Bethell et al., *Social Connection in Long-Term Care Homes: A Scoping Review of Published Research on the Mental Health Impacts and Potential Strategies During COVID-19*, 22 J. AM. MED. DIRS. ASS’N 228, 229 (2021).

Hence, during many months of COVID-19, “[v]irtually all nursing homes [were] in lockdown mode with residents unable to see their families or participate in communal meals or activities.”³⁹ There were limited social contacts among residents as policies in many nursing homes “sequester[ed] residents in their own rooms.”⁴⁰ A similar situation existed in assisted living communities and congregate homes for those living with disabilities who also lost the opportunity for visits from and to loved ones.⁴¹ With this painful deprivation,⁴² “[i]n effect, residents were placed in solitary confinement for six months.”⁴³ As a result, “[i]t is almost impossible to underestimate the harm and mental anguish that barring entry to nursing, care and residential homes has caused to thousands of residents, their families and significant others. Such action also supports the dangerous narrative that elderly and vulnerable people matter less.”⁴⁴

1. Pre-COVID-19 Visitor Policies in Congregate Residential Settings

The CMS, which regulates nursing homes, promulgated regulations that, in “normal” circumstances, recognize residents’ critical need for and rights

³⁹ Grabowski & Mor, *supra* note 19, at 23.

⁴⁰ Li, *supra* note 9, at 1691.

⁴¹ See generally U.N. OFF. OF THE HIGH COMM’R, COVID-19 AND THE RIGHTS OF PERSONS WITH DISABILITIES: GUIDANCE (2020), https://www.ohchr.org/sites/default/files/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf (addressing, broadly, the impact of COVID-19 on the basic rights of people with disabilities).

⁴² See Dana Shilling, *Agents of Shield? Limits on Liability Related to COVID-19*, ELDER L. ADVISORY, July 2020, 352 Elder Law Advisory NL 1 (observing that “even nursing home residents who were not infected experienced fear, social isolation and loss of activities important to them, and were essentially cut off from family members”).

⁴³ Dana Shilling, *Nursing Homes’ Cautious Reopening Amid the Pandemic*, ELDER L. ADVISORY, Nov. 2020, 356 Elder Law Advisory NL 1.

⁴⁴ Jules Storr et al., Opinion, *Open Letter: Infection Prevention and Control Should Never Be at the Expense of Compassionate Care*, NURSING TIMES (Oct. 16, 2020), <https://www.nursingtimes.net/opinion/open-letter-infection-prevention-and-control-should-never-be-at-the-expense-of-compassionate-care-16-10-2020/> [hereinafter *Open Letter*]; see also Suárez-González et al., *The Effect of COVID-19*, *supra* note 6, at 7 (warning that “[p]ublic infection control and prevention protocols affecting people with dementia have become a source of harm and they need, as a matter of urgency, to be redesigned under principles of non-maleficence and compassionate care”).

to companionship.⁴⁵ Congregate residential settings other than nursing homes are governed by a more complex panoply of local laws and regulations. However, CMS regulations provide a useful snapshot of pre-COVID-19 views on visitation.

CMS regulations establish that each nursing home resident “has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.”⁴⁶ In addition, the regulations proclaim that each “resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.”⁴⁷ More directly, they declare that each “resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident’s right to deny visitation when applicable, and *in a manner that does not impose on the rights of another resident.*”⁴⁸

The regulations protect mandatory “immediate access” to a specific list of individuals and officials—although this list does not include family, friends, or clergy members.⁴⁹ With respect to family, the regulations mandate that “[t]he facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident’s right to deny or withdraw consent at any time.”⁵⁰ For those outside family, regulations state that “[t]he facility must provide immediate access to a resident by others who are visiting with the consent of the resident, *subject to reasonable clinical and safety restrictions* and the resident’s right to deny or withdraw consent at any time,”⁵¹ and that “[t]he facility must provide *reasonable* access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident’s right to deny or withdraw consent at any time.”⁵² Perplexingly, clergy, chaplains, and providers of spiritual care are not included in the list of those

⁴⁵These regulations are discussed more fully in Giovenco, *supra* note 19, at 127–29.

⁴⁶42 C.F.R. § 483.10(a) (2022).

⁴⁷*Id.* § 483.10(f)(3).

⁴⁸*Id.* § 483.10(f)(4) (emphasis added).

⁴⁹*Id.* § 483.10(f)(4)(i) (establishing that this list of individuals who receive “immediate access” includes “any representative of the Secretary,” “any representative of the State,” “any representative of the Office of the State long term care ombudsman,” the “individual physician” of the resident, “any representative of the agency responsible for the protection and advocacy system for individuals with a mental disorder,” and “the resident representative”).

⁵⁰*Id.* § 483.10(f)(4)(ii).

⁵¹*Id.* § 483.10(f)(4)(iii) (emphasis added).

⁵²*Id.* § 483.10(f)(4)(iv) (emphasis added).

to whom the facility must grant “immediate access”⁵³—implying that legal and social services are deemed more important than spiritual care.

Underlying all these visitation rights is a general requirement that:

The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any *clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.*⁵⁴

With respect to gatherings, the regulations establish that “[t]he resident has a right to participate in other activities, including social, *religious*, and community activities that *do not interfere with the rights of other residents in the facility.*”⁵⁵ The right to gather for “religious . . . activities” is qualified by the caveat that it “not interfere with the rights of other residents.”⁵⁶

Embedded in this framework is the tension that underlies the COVID-19 lockdowns. The importance of dignity and autonomy in social interactions is recognized. With respect to family, there seems to be no qualification other than resident consent. Access required for those providing services must only be reasonable but not immediate.⁵⁷

Yet, gatherings and visitors are subject to the proviso that they be allowed “in a manner that does not impose on the rights” of other residents.⁵⁸ This language concerning clinical and safety restrictions and imposition on the rights of others offered a built-in rationale for the COVID-19 restrictions that suspended these rights. Even so, these regulations do not seem to anticipate the long-lasting, virtually complete bans on visitation that sprung up during the months when COVID-19 raged. That is a scenario for which very few planned.

Congregate settings other than nursing homes are also subject to stringent regulations, largely at the state level. Nevertheless, there, as well, the pre-

⁵³ *Id.* § 483.10(f)(4)(i).

⁵⁴ *Id.* § 483.10(f)(4)(v) (emphasis added).

⁵⁵ *Id.* § 483.10(f)(8) (emphasis added).

⁵⁶ *Id.*

⁵⁷ *See id.* § 483.10(f)(4)(iv).

⁵⁸ *Id.* § 483.10(f)(4).

COVID regime supported and encouraged visitation. Moreover, even the most cursory review of the websites and promotional material for congregate residential settings of all kinds demonstrates the great importance attached to social events and communal activities.

2. COVID-19 Visitation Policies

Once COVID-19 burst into the public eye, there were substantial changes to and suspension of visitation rights. It became clear very quickly that “our health care system is not well positioned to preserve family engagement during the COVID-19 crisis.”⁵⁹ This is where the problem lies.

Many restrictions that created the lengthy periods of enforced isolation were crafted in response to highly influential guidance promulgated by the CMS and CDC. Some were legally imposed—usually through the exercise of state governors’ emergency powers that, in essence, incorporated this federal guidance by reference. Alternatively, or simultaneously, they came in policies adopted by various facilities themselves. Although there was substantial variety in the ways these restrictions took shape, a brief survey reveals how extensive they were and the common features they shared.

a. Center for Medicare and Medicaid Services (“CMS”) Visitation Guidance

Although the CMS is primarily responsible for nursing homes, its guidance greatly influenced state and local visitation mandates for a range of congregate residential settings. It also shaped policies adopted by individual facilities.⁶⁰

On February 6, 2020, an early warning came in an *Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness* memorandum.⁶¹ This foreshadowed what was to come but gave little hint of

⁵⁹Susan Frampton et al., *Guidelines for Family Presence Policies During the COVID-19 Pandemic*, JAMA HEALTH F., July 2020, at 1, 1, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2768108>.

⁶⁰A helpful guide to the many COVID-19 guidance documents promulgated by CMS may be found at CTRS. FOR MEDICARE & MEDICAID SERVS., COVID-19 GUIDANCE AND UPDATES FOR NURSING HOMES DURING COVID-19 (2020), <https://www.cms.gov/files/document/covid-guidance-and-updates-nursing-homes-during-covid-19.pdf>.

⁶¹CTRS. FOR MEDICARE & MEDICAID SERVS., INFORMATION FOR HEALTHCARE FACILITIES CONCERNING 2019 NOVEL CORONAVIRUS ILLNESS (2019-NCov) (2020), <https://www.cms.gov/medicareprovider-enrollment-and->

the full extent of what would soon arise.⁶² It simply urged healthcare facilities to review information provided by the CDC,⁶³ examine existing emergency plans, and “review . . . appropriate personal protective equipment (PPE) use and availability, such as gloves, gowns, respirators, and eye protection.”⁶⁴

On March 4, 2020, two additional forms of guidance were issued by CMS that demonstrated increased concern about COVID-19. A *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes* memo⁶⁵ urged facilities to remain vigilant, communicate with their local health departments about suspected cases, and monitor residents for respiratory ailments.⁶⁶ With respect to isolation, it mandated only “triage and isolation of potentially infectious patients.”⁶⁷ It struck a compassionate tone, noting that “facilities should maintain a person-centered approach to care. This includes communicating effectively with patients, patient representatives and/or their family, and understanding their individual needs and goals of care.”⁶⁸ Nevertheless, it foreshadowed a glimpse of what would come with respect to visitation. It notes that visitors should be screened for risks and symptoms and warned that “a facility may need to restrict or limit visitation rights for reasonable clinical and safety reasons.”⁶⁹

The second memorandum, *Suspension of Survey Activities*,⁷⁰ announced that non-emergency inspections of nursing homes would be suspended in

certificationsurveycertificationgeninfopolicy-and-memos-states-and/information-healthcare-facilities-concerning-2019-novel-coronavirus-illness-2019-ncov [hereinafter CMS 2/6/20 MEMO].

⁶²For an early CDC report on the first high-profile COVID-19 nursing home outbreak, see Anne Kimball et al., *Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility — King County, Washington, March 2020*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 3, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e1.htm?scid=mm6913e1w>.

⁶³See discussion *infra* Section I.B.2.b concerning the guidance from the CDC.

⁶⁴CMS 2/6/20 MEMO, *supra* note 61, at 2.

⁶⁵CTRS. FOR MEDICARE & MEDICAID SERVS., GUIDANCE FOR INFECTION CONTROL AND PREVENTION OF CORONAVIRUS DISEASE 2019 (COVID-19) IN NURSING HOMES (Mar. 4, 2020), <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/qso-20-14-nh.pdf>.

⁶⁶*Id.* at 1.

⁶⁷*Id.*

⁶⁸*Id.* at 2.

⁶⁹*Id.*

⁷⁰CTRS. FOR MEDICARE & MEDICAID SERVS., SUSPENSION OF SURVEY ACTIVITIES (Mar. 4, 2020), <https://www.cms.gov/files/document/qso-20-12-all.pdf>. The topic of surveys was addressed again in CTRS. FOR MEDICARE & MEDICAID SERVS., PRIORITIZATION OF SURVEY ACTIVITIES (Mar. 20, 2020, updated Mar. 10, 2021), <https://www.cms.gov/files/document/qso-20-20-allpdf.pdf>

light of the growing concerns about COVID-19. Although not directly concerned with visitation, it illustrated increased fear about the ability to maintain normal operations in the nation's nursing homes.

Several days later, the CMS issued *Guidance for Use of Certain Industrial Respirators by Health Care Personnel*.⁷¹ This memo addressed the shortage of PPE and added flexibility in the types of face coverings that healthcare workers could employ. It did not mention visitation, but the fact that CMS was scrambling to offer this advice indicates how ill-prepared congregate residential settings were for what was to come.

Two dramatic changes came on March 13, 2020, when COVID-19 was declared a National Emergency. First, the CMS announced *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*.⁷² This meant that, for many critical issues, individual institutions would no longer have to apply for exceptions to CMS regulations governing their operations. Among the waived regulations were those related to visitation,⁷³ resident

(indicating that to the limited extent surveys were to continue, their focus would be on infection-control matters and issues relating to COVID-19 protocols). Survey-related issues were addressed again in documents such as CTRS. FOR MEDICARE & MEDICAID SERVS., REVISED COVID-19 SURVEY ACTIVITIES, CARES ACT FUNDING, ENHANCED ENFORCEMENT FOR INFECTION CONTROL DEFICIENCIES, AND QUALITY IMPROVEMENT ACTIVITIES IN NURSING HOMES (June 1, 2020, rev. Jan. 4, 2021), <https://www.cms.gov/files/document/qso-20-31-all-revised.pdf>; CTRS. FOR MEDICARE & MEDICAID SERVS., POSTING OF NURSING HOME INSPECTIONS (June 4, 2020), <https://www.cms.gov/files/document/qso-20-33-nh.pdf>; CTRS. FOR MEDICARE & MEDICAID SERVS., ENFORCEMENT CASES HELD DURING THE PRIORITIZATION PERIOD AND REVISED SURVEY PRIORITIZATION (Aug. 17, 2020), <https://www.cms.gov/files/document/qso-20-35-all.pdf>. After testing became more widely available, survey guidance was revised to address whether facilities were in compliance with the new testing regulations. *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., INTERIM FINAL RULE (IFC), CMS-3401-IFC, ADDITIONAL POLICY AND REGULATORY REVISIONS IN RESPONSE TO THE COVID-19 PUBLIC HEALTH EMERGENCY RELATED TO LONG-TERM CARE (LTC) FACILITY TESTING REQUIREMENTS AND REVISED COVID-19 FOCUSED SURVEY TOOL (Aug. 26, 2020), <https://www.cms.gov/files/document/qso-20-38-nh.pdf>.

⁷¹CTRS. FOR MEDICARE & MEDICAID SERVS., GUIDANCE FOR USE OF CERTAIN INDUSTRIAL RESPIRATORS BY HEALTH CARE PERSONNEL (Mar. 10, 2020), <https://www.cms.gov/files/document/qso-20-17-all.pdf>.

⁷²CTRS. FOR MEDICARE & MEDICAID SERVS., COVID-19 EMERGENCY DECLARATION BLANKET WAIVERS FOR HEALTH CARE PROVIDERS (Mar. 13, 2020). This set of blanket waivers has been consistently updated since the original version as conditions changed. Further information about the waivers was contained in a fact sheet released in March 2020 and available at <https://www.cms.gov/files/document/covid-19-blanket-waivers-section-1877g.pdf>.

⁷³*Id.* at 3 (waiving requirements of 42 C.F.R. § 482.13(h) “[r]elated to patient visitation, including the requirement to have written policies and procedures on visitation of patients who are in COVID-19 isolation and quarantine processes”).

groups in long-term care and skilled nursing facilities,⁷⁴ in-person visits for medical professionals,⁷⁵ and community group activities in facilities for individuals with intellectual disabilities.”⁷⁶

More importantly, the CMS issued its March 13, 2020, memorandum, *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes*.⁷⁷ This debuted stringent guidance for nursing homes. The heart of the guidance was that “[f]acilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation.”⁷⁸ This established the blanket guidance against all visitations. It also—intended or not—created the widespread perception that “compassionate” visitation was permissible only for end-of-life situations.⁷⁹

This guidance predicted situations where “a state implements actions that exceed CMS requirements, such as a ban on all visitation through a governor’s executive order.”⁸⁰ As discussed below, the confusing mélange of state regulations suggests that some state regulations were, in fact, more restrictive. Much was also said about the urgency of sanitation, testing staff and visitors, and providing appropriate PPE.⁸¹ Unfortunately, the latter two were often unfeasible because testing and PPE were limited in the

⁷⁴*Id.* at 18 (waiving requirements of 42 C.F.R. § 483.10(f)(5) “which ensure[s] residents can participate in person in resident groups”).

⁷⁵*Id.* at 18 (waiving requirements of 42 C.F.R. § 483.30 (which requires “physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options”).

⁷⁶*Id.* at 31–32 (waiving requirements of 42 C.F.R. § 483.420(a)(11) “which requires clients have the opportunity to participate in social, religious, and community group activities”).

⁷⁷CTRS. FOR MEDICARE & MEDICAID SERVS., GUIDANCE FOR INFECTION CONTROL AND PREVENTION OF CORONAVIRUS DISEASE 2019 (COVID-19) IN NURSING HOMES (REVISED) (Mar. 13, 2020, updated Mar. 10, 2021), <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf> [hereinafter CMS 3/13/20 MEMO]. Later, additional details were provided to state and local governments as well as facilities themselves in CTRS. FOR MEDICARE & MEDICAID SERVS., COVID-19 LONG-TERM CARE FACILITY GUIDANCE (Apr. 2, 2020), <https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf>. In the particular context of patient transfers, this guidance was supplemented yet again in CTRS. FOR MEDICARE & MEDICAID SERVS., 2019 NOVEL CORONAVIRUS (COVID-19) LONG-TERM CARE FACILITY TRANSFER SCENARIOS (Apr. 13, 2020), <https://www.cms.gov/files/document/qso-20-25-nh.pdf>.

⁷⁸CMS 3/13/20 MEMO, *supra* note 77, at 2 (emphasis omitted).

⁷⁹*Id.*

⁸⁰*Id.*

⁸¹*Id.* at 3–5.

pandemic's initial stages. In contrast, visitation limits were far easier to implement immediately.

This CMS memorandum spurred state and local regulations and policies at individual congregate residential settings—including institutions other than nursing homes. In addition to suspending visitation by family and friends, these restrictions often limited access to spiritual care. The definition of “compassionate care” does not explicitly allow clergy visits except in end-of-life situations.⁸² Moreover, “all group activities” were halted,⁸³ which, by definition, put an end to communal worship services.

New reporting requirements for COVID-19 cases in nursing homes⁸⁴ and updates on requirements for ratings, staff counts, and access to ombudsmen⁸⁵ soon followed. These expressed the growing concern about the disease and the rapidly changing landscape that made it, understandably, difficult to provide clear guidance. In an April 24, 2020, FAQ memo, CMS proposed ideas for virtual visitation⁸⁶ and funding for devices to facilitate virtual visitation.⁸⁷ This may have indicated both a recognition of the harms of isolation—and a concession that it may last a longer time than anticipated.

⁸²*Id.* at 2. Clergy are mentioned, along with bereavement counselors, as possible end-of-life visitors. However, even then, they would be admitted “on a case by case basis.”

⁸³*Id.* at 3.

⁸⁴CTRS. FOR MEDICARE & MEDICAID SERVS., UPCOMING REQUIREMENTS FOR NOTIFICATION OF CONFIRMED COVID-19 (OR COVID-19 PERSONS UNDER INVESTIGATION) AMONG RESIDENTS AND STAFF IN NURSING HOMES (Apr. 19, 2020), <https://www.cms.gov/files/document/qso-20-26-nh.pdf>; CTRS. FOR MEDICARE & MEDICAID SERVS., INTERIM FINAL RULE UPDATING REQUIREMENTS FOR NOTIFICATION OF CONFIRMED AND SUSPECTED COVID-19 CASES AMONG RESIDENTS AND STAFF IN NURSING HOMES (May 6, 2020), <https://www.cms.gov/files/document/qso-20-29-nh.pdf>. Updated standards concerning the release of COVID-19 data followed in June. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., RELEASE OF COVID-19 NURSING HOME DATA (June 4, 2020), <https://www.cms.gov/files/document/qso-20-32-nh.pdf>.

⁸⁵CTRS. FOR MEDICARE & MEDICAID SERVS., NURSING HOME FIVE STAR QUALITY RATING SYSTEM UPDATES, NURSING HOME STAFF COUNTS, FREQUENTLY ASKED QUESTIONS, AND ACCESS TO OMBUDSMAN (REVISED) (Apr. 24, 2020, rev. July 9, 2020, updated Mar. 10, 2021), <https://www.cms.gov/files/document/qso-20-28-nh-revised.pdf> [hereinafter CMS 4/24/2020 MEMO]. Related issues were addressed again in CTRS. FOR MEDICARE & MEDICAID SERVS., CHANGES TO STAFFING INFORMATION AND QUALITY MEASURES POSTED ON THE NURSING HOME COMPARE WEBSITE AND FIVE STAR QUALITY RATING SYSTEM DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY (June 25, 2020), <https://www.cms.gov/files/document/qso-20-34-nh.pdf>.

⁸⁶CMS 4/24/2020 MEMO, *supra* note 85, at FAQ #2.

⁸⁷*Id.* at FAQ # 3.

On May 18, 2020, the CMS updated its guidelines in *Nursing Home Reopening Recommendations for State and Local Officials*.⁸⁸ This proposed a gradual, detailed, phased approach to reopening nursing homes based on a panoply of factors including community spread, presence of COVID-19 in individual facilities, adequacy of staff, and sufficient testing capacity.⁸⁹ With respect to visitations, regulations eased as an individual facility's location entered safer phases. The most stringent phase still proposed "[r]estricted entry of non-essential healthcare personnel."⁹⁰ This memorandum was confusing, and the number of variables it identified made it difficult to state with certainty what was allowed. This is understandable because, at that time, states were in different situations, and much remained unknown.

In addition, while May 18, 2020, found many residents already two months into forced isolation, it was still possible to believe this would be temporary. Many did not yet realize the restrictions' long-term impact. In addition to the direct applicability of these guidelines to nursing homes, the CDC noted that while "[t]his guidance was created specifically for nursing homes . . . content might also be informative for [Assisted Living Facilities.]"⁹¹ This illustrates how influential this CMS guidance was beyond the nursing home sector.

At the same time, the CMS also released *Nursing Home Reopening Recommendations Frequently Asked Questions*⁹² to provide greater clarity. In this document, the CMS reiterated its guidance banning visitation until "phase three" when "there have been no new, nursing home onset COVID-19 cases . . . for 28 days."⁹³ While this appeared to loosen restrictions, this was often false hope. In large congregate residential settings, the likelihood

⁸⁸CTRS. FOR MEDICARE & MEDICAID SERVS., NURSING HOME REOPENING RECOMMENDATIONS FOR STATE AND LOCAL OFFICIALS (REVISED) (May 18, 2020, rev. Mar. 10, 2021), <https://www.cms.gov/files/document/qso-20-30-nh.pdf-0>.

⁸⁹*Id.* at 2–3.

⁹⁰*Id.* at 5.

⁹¹CTRS. FOR DISEASE CONTROL & PREVENTION, CONSIDERATIONS FOR PREVENTING SPREAD OF COVID-19 IN ASSISTED LIVING FACILITIES (last updated May 29, 2020), <https://public4.pagefreezer.com/browse/CDC%20Covid%20Pages/11-05-2022T12:30/https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html> [hereinafter CDC 5/29/20 GUIDANCE].

⁹²CTRS. FOR MEDICARE & MEDICAID SERVS., NURSING HOME REOPENING RECOMMENDATIONS FREQUENTLY ASKED QUESTIONS (May 18, 2020), <https://www.cms.gov/files/document/covid-nursing-home-reopening-recommendation-faqs.pdf> [hereinafter CMS 5/18/20 FAQ].

⁹³*Id.* at 1; *see also id.* at 4–5.

of one resident or staff member testing positive within a four-week period remained significant. This would “reset the clock” for another twenty-eight days.⁹⁴ The document fleetingly acknowledged that “to restrict visitation is understandably challenging for families,”⁹⁵ but does little to ameliorate this other than declare the restrictions “necessary in order to protect residents from possible transmission of the virus.”⁹⁶ The FAQs do not address spiritual care, nor do they clearly define “compassionate care situations.”⁹⁷

It was not until September 17, 2020, that the CMS issued *Nursing Home Visitation—COVID-19*, with updated visitation guidelines⁹⁸ that explicitly recognized that, after so many months:

[P]hysical separation from family and other loved ones has taken a physical and emotional toll on residents. Residents may feel socially isolated, leading to increased risk for depression, anxiety, and other expressions of distress. Residents living with cognitive impairment or other disabilities may find visitor restrictions and other ongoing changes related to COVID-19 confusing or upsetting. CMS understands that nursing home residents derive value from the physical, emotional, and spiritual support they receive through visitation from family and friends.⁹⁹

Thus, *a full six months* after nearly all visitors were banned, the collateral damage that resulted from lockdown was finally acknowledged.

This guidance made significant steps forward. With fewer restrictions, it encouraged outdoor visitation when feasible.¹⁰⁰ With respect to indoor visitation, significant strides were made. The guidance indicated that such visits should be allowed “for reasons beyond compassionate care situations.”¹⁰¹ It further recognized that “compassionate care situation” may have been viewed too narrowly and indicated that it should not “exclusively refer to end-of-life situations,”¹⁰² but should be viewed more broadly.

⁹⁴ *Id.* at 1.

⁹⁵ *Id.* at 4.

⁹⁶ *Id.*

⁹⁷ *See id.*

⁹⁸ This revised guidance from the CMS is discussed more fully in Shilling, *supra* note 43.

⁹⁹ *See* CMS 9/17/20 MEMO, *supra* note 5, at 2.

¹⁰⁰ *Id.* at 3.

¹⁰¹ *Id.*

¹⁰² *Id.* at 4.

Examples were given of those “struggling with the change in environment and lack of physical family support,”¹⁰³ “grieving after a friend or family member recently passed away,”¹⁰⁴ requiring assistance with eating or drinking,¹⁰⁵ or “experiencing emotional distress.”¹⁰⁶

Moreover, after six long months, the memo explicitly recognized the importance of spiritual care, noting that “in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident’s needs, such as *clergy or lay persons offering religious and spiritual support*.”¹⁰⁷ In stronger terms, clergy were included in the list of “Health Care Workers and Other Providers of Services”¹⁰⁸ who “must be permitted to come into the facility” unless they have been exposed to COVID-19 or have symptoms of it.¹⁰⁹ While categorizing clergy with such professionals as “hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, [and] social workers”¹¹⁰ may not reflect the way clergy view their vocations, it does recognize spiritual care as critical to holistic care. This categorization also strengthens residents’ claims to clergy visits in times of need.¹¹¹

Yet, a double-edged sword was again embedded in the guidelines. It required that “if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, a nursing home *must* facilitate in-person visitation consistent with the regulations.”¹¹² However, the corollary to this imperative was that indoor visits *could* be suspended if there has been a COVID-19 case in the facility within fourteen days. Given the large numbers of staff and residents at many facilities, the chances of a single case

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* (emphasis added).

¹⁰⁸ *Id.* at 6.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.* at 4. Nevertheless, there were limitations in this memorandum with respect to spiritual care. *See id.* The definition of “compassionate care” did not clarify whether “routine” visits from those providing religious or spiritual support were allowed or whether they would only be accommodated in cases of distress. *Id.* Second, including clergy in the discussion of both “compassionate care visits” and service providers creates the potential for confusion. *Id.* at 4, 6.

¹¹² *Id.* at 5.

remained high. One such case would lock the facility down again, with only limited exceptions.¹¹³

In February 2021, nearly a year after the first restrictions, the CMS issued a memorandum specifically directed to congregate residential settings beyond nursing homes. This memorandum, *Visitation at Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and Psychiatric Residential Treatment Facilities (PRTFs)—Coronavirus Disease-2019 (COVID-19)*,¹¹⁴ tracked much of the September 2020 guidance for nursing homes. It included nearly identical language acknowledging the cost of isolation measures¹¹⁵ but granted much discretion to facilities to “determine what visitation policies and procedures to implement based on local community prevalence of COVID-19 and federal, state and local requirements and guidance.”¹¹⁶ It included similar language on compassionate care, noting that this “does not exclusively refer to end-of-life situations,”¹¹⁷ and acknowledging that “clergy or laypersons offering religious or spiritual support”¹¹⁸ can provide such visits. It also categorized clergy as “healthcare personnel” for purposes of visitation.¹¹⁹ However, it also allowed shutdowns—except for “compassionate care”¹²⁰ visitation—in the too-common event of a COVID-19 case among staff or residents within the last fourteen days.¹²¹

Finally, on March 10, 2022, the CMS issued clear guidance in the form of updates to its September 17, 2020, memorandum that stated unequivocally that:

¹¹³ *See id.* at 3. While an outdoor visit would still be permitted in such circumstances, for many residents, medical conditions or inclement weather may preclude this.

¹¹⁴ CTRS. FOR MEDICARE & MEDICAID SERVS., VISITATION AT INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IIDs) AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTFs)—CORONAVIRUS DISEASE-2019 (COVID-19) (Feb. 10, 2021), <https://www.cms.gov/files/document/qso-21-14-icf-iid-prtf.pdf>.

¹¹⁵ *See id.* at 2.

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 6 (emphasis omitted). Interestingly, however, while many of the examples of compassionate care exceptions are similar to those in the September 2020 guidance for nursing home residents, no provision for grieving residents is included here. *See id.* It is unclear if that was an oversight or an intentional discrepancy.

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 7.

¹²⁰ *See id.* at 4.

¹²¹ *See id.* Nevertheless, this was better than the twenty-eight-day restriction in prior guidance. *See* CMS 5/18/20 FAQ, *supra* note 92, at 1.

Facilities must allow indoor visitation at all times and for all residents as permitted under the [pre-COVID-19] regulations. While previously acceptable during the PHE, facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.¹²²

The September 17, 2020, memorandum was revised again on September 23, 2022, to provide additional guidance for visitors—guidance with a decidedly more welcoming tone. It warned that “[v]isitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation,”¹²³ while visitors who were “close contacts” of someone infected with COVID-19 would find it “safest to defer non-urgent in-person visitation.”¹²⁴ It still warned of the risks of visitation but contemplated that there would again be significant interaction between residents and their chosen family and friends—and each other.¹²⁵

b. Centers for Disease Control (“CDC”) Guidance

The CDC likewise issued guidance concerning infection control at congregate residential settings. This highly influenced mandates adopted by local jurisdictions and individual facilities. It was particularly influential in

¹²²CTRS. FOR MEDICARE & MEDICAID SERVS., NURSING HOME VISITATION—COVID-19 (REVISED) 4 (Sept. 17, 2020, rev. Sept. 23, 2022), <https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf> [hereinafter CMS 9/23/22 MEMO]. For responses to this development, see Amy Goldstein, *Federal Officials Relax Guidance on Nursing Home Visits, Citing Vaccines and Slowing Infections*, WASH. POST (Mar. 10, 2021), https://www.washingtonpost.com/health/covid-nursing-home-visits/2021/03/10/4214165a-81d4-11eb-9ca6-54e187ee4939_story.html.

¹²³CMS 9/23/22 MEMO, *supra* note 122, at 3.

¹²⁴*Id.*

¹²⁵The memo explained:

Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that . . . does not increase risk to other residents. During peak times of visitation and large gatherings (e.g., parties, events) facilities should encourage physical distancing.

Id. at 4.

settings other than nursing homes, which were more directly covered by the CMS guidelines.¹²⁶

The CDC's first significant foray into visitation came in *Responding to Coronavirus (COVID-19) in Nursing Homes*.¹²⁷ This dealt primarily with caring for and cohorting residents infected—or suspected of being infected—rather than blanket restrictions for all.

This was updated in the CDC's March 29, 2021, guidance, *Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes*.¹²⁸ Issued after COVID-19 vaccines became widely available, visitation guidelines were tentatively updated. These updates asserted that while the recommendations “are specific for nursing homes, including skilled nursing facilities, [they] may also apply to other long-term care and residential settings.”¹²⁹ With respect to visitation, this update offered little clear guidance. It vaguely told facilities to have a “plan for managing visitation, including use of restrictions when necessary.”¹³⁰ It incorporated by reference the CMS visitation guidance¹³¹ along with state and local restrictions.

Later, on April 27, 2021, the CDC issued *Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19*

¹²⁶The complex array of regulations and the panoply of regulatory authorities for diverse types of congregate residential settings also make it more difficult to develop a comprehensive picture of the scope of the harm. As one commentator noted, “there is no nationwide, comprehensive dataset available on COVID-19 cases and deaths across all congregate care settings, including those that primarily serve people with disabilities.” Antonisse, *supra* note 3, at 1803. Attempts at assessing the impact of COVID-19 in assisted living communities are addressed in Kali S. Thomas et al., *Estimation of Excess Mortality Rates Among US Assisted Living Residents During the COVID-19 Pandemic*, JAMA NETWORK OPEN, June 2021, at 1, 1, <https://jamanetwork.com/journals/jamanetworkopen/issue/4/6>.

¹²⁷CTRS. FOR DISEASE CONTROL & PREVENTION, RESPONDING TO CORONAVIRUS (COVID-19) IN NURSING HOMES (Apr. 30, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html> [<https://www.hsdl.org/?abstract&did=837597>].

¹²⁸CTRS. FOR DISEASE CONTROL & PREVENTION, INTERIM INFECTION PREVENTION AND CONTROL RECOMMENDATIONS TO PREVENT SARS-COV-2 SPREAD IN NURSING HOMES (updated Mar. 29, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

[https://cdn.ymaws.com/www.leadingageflorida.org/resource/resmgr/covid-19/2021/05/Interim_Infection_Prevention.pdf].

¹²⁹*Id.*

¹³⁰*Id.*

¹³¹See discussion *supra* Section I.B.2.a.

*Vaccination.*¹³² This was its most expansive visitation guidance, lessening visitation restrictions significantly as vaccination rates rose. For post-acute facilities such as nursing homes, the guidance said, with few exceptions, “[i]ndoor visitation could be permitted for all residents.”¹³³ Unvaccinated residents could see visitation limited in situations with a high county positivity rate (over ten percent) and a low (under seventy percent) vaccination rate among residents in the facility.¹³⁴ Beyond that, most limitations applied only in cases of actual infection. In acute care facilities, there was a general statement that visits should be “prioritized for those visitors important [to] the patient’s physical or emotional well-being and care.”¹³⁵ This did not require visitor vaccination but recommended that “vaccination for visitors is always preferred, when possible.”¹³⁶

The CDC also issued guidance specifically related to a broad range of healthcare personnel—including those who work in nursing home and congregate residential settings.¹³⁷

The CDC also provided additional guidance tailored to specific types of congregate residential settings.¹³⁸ For example, the CDC’s May 29, 2020, *Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities*¹³⁹ highlighted visitation restrictions as assisted living facilities reopened. It was far less detailed than the CMS guidance but included

¹³²CTRS. FOR DISEASE CONTROL & PREVENTION, UPDATED HEALTHCARE INFECTION PREVENTION AND CONTROL RECOMMENDATIONS IN RESPONSE TO COVID-19 VACCINATION (updated Apr. 27, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html> [<https://stacks.cdc.gov/view/cdc/105524>].

¹³³*Id.*

¹³⁴*Id.*

¹³⁵*Id.*

¹³⁶*Id.*

¹³⁷CTRS FOR DISEASE CONTROL & PREVENTION, INTERIM INFECTION PREVENTION AND CONTROL RECOMMENDATIONS FOR HEALTHCARE PERSONNEL DURING THE CORONAVIRUS DISEASE 2019 (COVID-19) PANDEMIC (updated Sept. 23, 2022), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>.

¹³⁸Although beyond the scope of this article, the CDC also issued CTRS. FOR DISEASE CONTROL & PREVENTION, RECOMMENDATIONS FOR QUARANTINE DURATION IN CORRECTIONAL AND DETENTION FACILITIES (updated June 9, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/community/quarantine-duration-correctional-facilities.html> [<https://stacks.cdc.gov/view/cdc/107038>], to address related issues in the context of correctional and detention facilities.

¹³⁹CDC 5/29/20 GUIDANCE, *supra* note 91.

recommendations such as “[e]ncourage residents to limit outside visitors,”¹⁴⁰ and acknowledged that “[i]n some jurisdictions, a total restriction of visitors might be warranted.”¹⁴¹ It also urged facilities to make an “inventory of all volunteers and personnel who provide care . . . [and] [u]se that inventory to determine which personnel are non-essential and whose services can be delayed.”¹⁴² It noted further that “a total restriction of all volunteers and non-essential personnel”¹⁴³ could be warranted. This left much discretion to facilities as to who is “essential” and included no guidance on spiritual care and clergy visits.¹⁴⁴ Unsurprisingly, the guidance also directs facilities to “[m]odify or cancel group activities”¹⁴⁵ thus impeding important sources of communal support, including gatherings for worship.

The CDC also issued *COVID-19 Guidance for Shared or Congregate Housing*.¹⁴⁶ This was geared toward residences that were not healthcare facilities, including “a broad range of settings, such as apartments, condominiums, student or faculty housing, national and state park staff housing, transitional housing, and domestic violence and abuse shelters.”¹⁴⁷ The guidance offered on visitation in these contexts was, predictably, less restrictive than that proffered for healthcare settings. It suggested “limiting the number of non-essential visitors to workers, volunteers, and visitors who are essential to preserving the health, including the mental health, well-being, and safety of residents.”¹⁴⁸ Because residents of the settings covered by this

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ Interestingly, the CDC also issued CTRS. FOR DISEASE CONTROL & PREVENTION, GUIDANCE FOR DIRECT SERVICE PROVIDERS (updated Dec. 16, 2020), <https://www.cdc.gov/ncbddd/humandevlopment/covid-19/guidance-for-direct-service-providers.html>, in which it offered guidance for those who provide “personal care” to persons with disabilities in a number of residential settings, including private homes, community settings, group homes, and day programs. It acknowledges that these services are “essential for the health and well-being of the people they serve.” *Id.* It offers comprehensive guidance for the ways such “essential” service providers can visit those they serve. However, it does not mention clergy members or those who provide spiritual care.

¹⁴⁵ CDC 5/29/20 GUIDANCE, *supra* note 91.

¹⁴⁶ CTRS. FOR DISEASE CONTROL & PREVENTION, COVID-19 GUIDANCE FOR SHARED OR CONGREGATE HOUSING (updated Aug. 22, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/index.html> [<https://stacks.cdc.gov/view/cdc/92388>].

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

guidance may not have been as physically vulnerable as those in nursing homes, assisted living facilities, and group homes, this greater flexibility is unsurprising.

The CDC's *Updated Considerations for Retirement Communities and Independent Living Facilities*¹⁴⁹ addressed congregate living communities that do not provide medical services. Labeled "considerations,"¹⁵⁰ the tone was more flexibly advisory than other documents. Nevertheless, it still provided a basis for facilities to impose regulations such as moving activities, including religious services, to a virtual format¹⁵¹ and "limiting the number of non-essential visitors to workers, volunteers, and visitors who are essential to preserving the health, including mental health, well-being, and safety of residents."¹⁵² While those providing spiritual care were not mentioned explicitly, the "well-being"¹⁵³ phrase should include them.

Shortly thereafter, the CDC issued *Guidance for Group Homes for Individuals with Disabilities*.¹⁵⁴ This left much discretion to individual group homes. It did, however, indicate that homes may want to "limit visitation . . . allowing only workers, volunteers, and visitors who are essential to preserving the physical and mental health, well-being, and safety of residents."¹⁵⁵ This would seem to allow for visitors who provide spiritual care. However, it did not clearly require that such visits be allowed.

The CDC also issued guidelines called *Management of Visitors to Healthcare Facilities in the Context of COVID-19: Non-US Healthcare Settings*.¹⁵⁶ These guidelines did not provide significant detail as to various

¹⁴⁹CTRS. FOR DISEASE CONTROL & PREVENTION, CONSIDERATIONS FOR RETIREMENT COMMUNITIES AND INDEPENDENT LIVING FACILITIES (updated Oct. 30, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/community/retirement/index.html> [<https://www.hSDL.org/?view&did=851694>].

¹⁵⁰*Id.*

¹⁵¹*Id.*

¹⁵²*Id.*

¹⁵³*See id.*

¹⁵⁴CTRS. FOR DISEASE CONTROL & PREVENTION, GUIDANCE FOR GROUP HOMES FOR INDIVIDUALS WITH DISABILITIES (updated May 17, 2021), [<https://public4.pagefreezer.com/browse/CDC%20Covid%20Pages/11-05-2022T12:30/https://www.cdc.gov/coronavirus/2019-ncov/community/group-homes.html>].

¹⁵⁵*Id.*

¹⁵⁶CTRS. FOR DISEASE CONTROL & PREVENTION, MANAGEMENT OF VISITORS TO HEALTHCARE FACILITIES IN THE CONTEXT OF COVID-19: NON-US HEALTHCARE SETTINGS (updated Sept. 15, 2020) [<https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/index.html>].

types of visitors but generally discouraged visitation. The document noted, “[v]isitors are strongly discouraged from visiting patients who are at increased risk for severe illness from COVID-19.”¹⁵⁷ Given that a high percentage of those in congregate residential settings are at heightened risk levels, this is discouraging.

Finally, the CDC issued *Considerations for Communities of Faith*.¹⁵⁸ On its face, this was highly deferential to faith communities, noting it “is not intended to infringe on rights protected by the First Amendment . . . or any other federal law,”¹⁵⁹ and stating that “[t]he federal government may not prescribe standards for interactions of faith communities in houses of worship.”¹⁶⁰ It also makes two important statements about spiritual care, noting:

- “Millions of Americans embrace worship as an essential part of life. For many faith traditions, gathering together for worship is at the heart of what it means to be a community of faith;”¹⁶¹ and
- “[W]hile many types of gatherings are important for civic and economic well-being, religious worship has particularly profound significance to communities and individuals.”¹⁶²

However, it says nothing about the importance of religion or faith communities for residents of congregate residential settings.

c. State and Local Restrictions on Visitation in Congregate Residential Settings

While the CMS and CDC guidance were influential—particularly with respect to nursing homes—much of the regulations that isolated those in congregate residential settings were legally imposed by state and local orders.¹⁶³ Some were more stringent than those suggested by the CMS and

[<https://web.archive.org/web/20210112223659/https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/hcf-visitors.html>].

¹⁵⁷ *Id.*

¹⁵⁸ CTRS. FOR DISEASE CONTROL & PREVENTION, *CONSIDERATIONS FOR COMMUNITIES OF FAITH* (updated Dec. 14, 2020) [<https://stacks.cdc.gov/view/cdc/98788>].

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ For overviews of the state and local orders in place, see generally Andy Markowitz & Emily Paulin, *AARP Answers: Nursing Homes and the Coronavirus*, AM. ASS’N OF RETIRED PERS., <https://www.aarp.org/caregiving/health/info-2020/nursing-home-visits-by-state.html> (last updated

CDC. Others were vague as to what “compassionate care visit” and “essential care” entailed, and many incorporated the CMS or CDC standards by reference. Very few recognized the importance of spiritual care. What is clear is that there was enormous variety in the ways states responded to federal guidance and regulations.¹⁶⁴ Many of these are highlighted in the CMS *Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes*.¹⁶⁵ While extensive analysis of all state and local restrictions is beyond the scope of this article, some general themes emerge.¹⁶⁶

First, and predictably, many included state waivers of general regulations due to the COVID-19 emergency.¹⁶⁷ This was an initial step, quickly undertaken.

Many were outright bans on all visitors except for end-of-life scenarios. For example, New Jersey’s *Mandatory Guidelines for Visitors and Facility Staff* said bluntly, “no resident visitors shall be permitted in the facility except for end-of-life situations.”¹⁶⁸ Some states, as time went on, expanded “compassionate care” to circumstances beyond end-of-life, including clergy visits.¹⁶⁹

Mar. 16, 2022). See also *Federal and State Nursing Home & Assisted Living Regulations: Transparency, Safety and Living Resources for All 50 States*, SENIORLIVING.ORG, <https://www.seniorliving.org/nursing-homes/state-federal-regulations/> (last updated Apr. 2021) (providing links to state-by-state data on regulations governing nursing homes and assisted living communities).

¹⁶⁴See Jennifer Abbasi, *Social Isolation—The Other COVID-19 Threat in Nursing Homes*, 324 J. AM. MED. ASS’N 619, 619 (2020) (“Visitation varies significantly state by state, for reasons that have little to do with differences in coronavirus prevalence or risk.”).

¹⁶⁵CTRS. FOR MEDICARE & MEDICAID SERVS., *TOOLKIT ON STATE ACTIONS TO MITIGATE COVID-19 PREVALENCE IN NURSING HOMES* 151–61 (Mar. 2022), <https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf> [hereinafter CMS TOOLKIT].

¹⁶⁶For a comprehensive listing of state and local health authorities, see generally *Directory of Local Health Departments*, NAT’L ASS’N CNTY. & CITY HEALTH OFFS., <https://www.naccho.org/membership/lhd-directory> (last visited Sept. 1, 2022).

¹⁶⁷See, e.g., Ala. Proclamation, *State of Emergency: Coronavirus (COVID-19)*, (Mar. 13, 2020), <https://governor.alabama.gov/newsroom/2020/03/state-of-emergency-coronavirus-covid-19/>.

¹⁶⁸N.J. DEP’T OF HEALTH, *MANDATORY GUIDELINES FOR VISITORS AND FACILITY STAFF 2* (Mar. 16, 2020), https://www.nj.gov/health/legal/covid19/3-16-2020_MandatoryGuidelinesforVisitors_andFacilityStaff_%20Supersedes3-13-2020Guidelines.pdf.

¹⁶⁹See, e.g., ARIZ. DEP’T OF HEALTH SERVS., *COVID-19 GUIDANCE FOR VISITATION AT CONGREGATE SETTINGS FOR VULNERABLE ADULTS AND CHILDREN 2* (revised Apr. 2, 2021)

Unfortunately, like the CMS, many state regulations suspended visitation if there was a positive case within the facility for a period of fourteen days, essentially resetting the clock. This was true even after visitation rules loosened for other purposes.¹⁷⁰ The practical effect of this was lengthened isolation at many facilities.

Many jurisdictions granted much discretion to individual facilities.¹⁷¹ Although this was scaled back as conditions improved, guidance remained deferential to the judgments of individual facilities and their assessment of local risks, staff resources, and ability to provide safeguards against infection. States often conditioned visitation on the degree of community spread as measured by relevant positivity rates.¹⁷² Virtual visitation was also enthusiastically promoted as an alternative means of retaining family contact.

As restrictions loosened, some states allowed access to a limited number of visitors¹⁷³ or with COVID-19 testing of visitors.¹⁷⁴ If allowed, visitors were required to follow infection control protocols that included such things as mask-wearing, sanitizing, contact tracing, limited visitation locations,

(stating that a “compassionate care visit” can include visits by “clergy” among other specifically enumerated people). A more in-depth discussion of these changes is included *infra*.

¹⁷⁰See, e.g., MO. DEP’T OF HEALTH & SENIOR SERVS., GUIDANCE FOR LONG TERM CARE FACILITIES TO ESTABLISH ESSENTIAL CAREGIVER PROGRAMS AND TO ALLOW VISITS 5 (Sept. 22, 2020), <https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/pdf/visitation-guidance.pdf>; ARIZ. DEP’T OF HEALTH SERVS., *supra* note 169, at 12.

¹⁷¹For example, while the state of Missouri established an “Essential Caregiver” program that would expand resident access to designated visitors, MO. DEP’T OF HEALTH & SENIOR SERVS., *supra* note 170. It also established that “[e]ach facility will make the final decision to establish an Essential Caregiver program or to allow visits.” *Id.* at 1.

¹⁷²See, e.g., ARIZ. DEP’T OF HEALTH SERVS., *supra* note 169, at 3 (benchmarking positivity rates).

¹⁷³See, e.g., ALA. STATE BD. OF HEALTH, ORDER OF THE STATE HEALTH OFFICER SUSPENDING CERTAIN PUBLIC GATHERINGS DUE TO RISK OF INFECTION BY COVID-19 10 (amended Sept. 30, 2020), <https://governor.alabama.gov/assets/2020/09/Safer-at-Home-Order-Final-9.29.2020.pdf> (limiting residents in Alabama’s congregate residential settings to one visitor at a time, subject to significant restrictions and subject to applicable federal guidance from the CMS); *Proceeding with Caution: Updated Statewide COVID-19 Health Order for Alabama*, STATE OF ALA. (Mar. 4, 2021), <https://governor.alabama.gov/assets/2021/03/GKI-Health-Order-Update-04.09.21-Horizontal.pdf> (increasing the acceptable number of visitors in Alabama’s nursing homes and assisted living facilities to two effective March 4, 2021).

¹⁷⁴See, e.g., CAL. DEP’T OF PUB. HEALTH, GUIDANCE FOR LIMITING THE TRANSMISSION OF COVID-19 IN SKILLED NURSING FACILITIES (SNFS) (Aug. 12, 2021), <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-22.aspx> (requiring any unvaccinated visitor to a congregate residential setting to have a negative COVID-19 test prior to entry).

training, screening,¹⁷⁵ restrictions on visit lengths, and further loosening of restrictions as vaccination increased. Liberal access to outdoor visitation became common.¹⁷⁶ Even when inside visitation was authorized, there were clear preferences for outside visits when they were possible.¹⁷⁷

However, after restrictions began to follow a general trajectory toward flexibility, the arrival of the delta and then omicron variants of COVID-19 sparked some setbacks. For example, California adopted mandatory COVID-19 testing for unvaccinated visitors,¹⁷⁸ and concern was voiced about what this meant for the safety of those in congregate residential settings.¹⁷⁹ Some visitors, including students, attorneys, ombudsmen, surveyors, and health care providers were exempt, but clergy were not exempt unless their visits were in the context of “compassionate care.”¹⁸⁰ However, even with heightened concern raised by new variants, widespread lockdowns did not occur again.

d. Individual Institutional Policies

Individual institutions also crafted their own visitation restrictions. These were often quite strict because facilities were understaffed¹⁸¹ or because their leaders feared legal liability¹⁸² or ramifications for their insurability.¹⁸³

¹⁷⁵ See, e.g., ARIZ. DEP’T OF HEALTH SERVS., *supra* note 169, at 6.

¹⁷⁶ See, e.g., *id.* at 4.

¹⁷⁷ See, e.g., *id.* at 5.

¹⁷⁸ See generally CAL. DEP’T OF PUB. HEALTH, *supra* note 174.

¹⁷⁹ See, e.g., Alanna Quillen, *Omicron Renews Concerns for Long-Term Care Communities*, NBC NEWS DFW (Dec. 30, 2021, 9:00 AM), <https://www.nbcdfw.com/news/local/omicron-renews-concerns-for-long-term-care-communities/2848503/>.

¹⁸⁰ See CAL. DEP’T OF PUB. HEALTH, *supra* note 174.

¹⁸¹ See Abbasi, *supra* note 164, at 620 (“Many homes were too short-handed, thanks to the industry’s longstanding staffing problems that were exacerbated by the pandemic, and outside volunteers weren’t allowed in.”); *id.* (“Exactly what each nursing home chose to do inside and out was highly variable . . . and was often based on staffing levels.”).

¹⁸² *Id.* at 619 (quoting Dr. Lea Watson, who observed that owners of many congregate residential settings “are living in complete fear of getting exposed for an infection control violation and so they’re being more strict than they need to be.”).

¹⁸³ See Robin Fretwell Wilson et al., *COVID-19 and the Assembly of Believers: From Rights to Responsibility*, BERKLEY CTR. FOR RELIGION, PEACE & WORLD AFFS.: BERKLEY F. (June 3, 2020), <https://berkeleycenter.georgetown.edu/responses/covid-19-and-the-assembly-of-believers-from-rights-to-responsibility> (“The insurance industry has pointed out that violating state executive orders may result in no coverage under commercial liability coverage policies.”); see generally SAFE

Unfortunately, perhaps due to these factors, “[a]ccording to CMS, some nursing homes may have been overly restrictive on visitation in a manner that was inconsistent with CMS guidance.”¹⁸⁴ Short-staffed facilities were least able to accommodate visitation. Yet, in a cruel irony, residents in such facilities most needed the personal care of family and friends.

Individual institutions varied a great deal in their approaches.¹⁸⁵ The contours of such individual facility responses were, by necessity, driven by such things as applicable local laws, sufficiency of staffing, medical condition of residents, local transmission rates, number of residents, physical layout of the facility, and availability of suitable outdoor visitation locations. However, until federal and state guidance allowed—and, later, came to require—a return to visitation, facilities were extraordinarily cautious about visitation.

PRACTICES WITH COMPASSION, enablesafecare.org (offering proposed protocol for safe visitation in congregate residential settings).

¹⁸⁴GAO-22-105133, *supra* note 1, at 14.

¹⁸⁵*See generally* CMS TOOLKIT, *supra* note 165 (including illustrative policies and protocols from healthcare and congregate residential settings nationwide).

II. THE DEVASTATING AFTERMATH OF COVID-19 VISITATION RESTRICTIONS

Even if stringent initial restrictions on visitation were understandable at the dawn of the pandemic, the isolation that followed had grave consequences for vulnerable people physically,¹⁸⁶ mentally,¹⁸⁷ and spiritually.

¹⁸⁶See, e.g., Levere et al., *supra* note 34, at 950 (noting increase in “unplanned substantial weight loss, and incontinence, as well as worsened cognitive functioning” of nursing home patients during COVID-19); Jenny Paananen et al., *The Impact of Covid-19-Related Distancing on the Well-Being of Nursing Home Residents and Their Family Members: A Qualitative Study*, INT’L J. NURSING STUD. ADVANCES, Nov. 2021, at 1, 3 (“It is known that social isolation increases morbidity and mortality”); U.N. POLICY BRIEF, *supra* note 7, at 9 (noting that “[f]or the many millions of older persons who live in care facilities, physical distancing measures that restrict visitors and group activities can negatively affect the physical and mental health and well-being of older persons, particularly those with cognitive decline or dementia, and who are highly care-dependent” (footnote omitted)); and SUÁREZ-GONZÁLEZ ET AL., IMPACT OF COVID-19 ON PEOPLE LIVING WITH DEMENTIA, *supra* note 6, at 12 (lamenting that “the ‘confinement disease’—the effect of leaving people alone in their rooms due to staff shortages with no assistance for drinking and eating—may have proven to be even more deleterious than the virus itself.”). Suárez-González and others observed:

People with dementia in care homes are believed to have gone through the hardest version of Covid-19, both in term of mortality and deleterious effects of confinement, including decisions such as not referring to hospitals and ban on visitors which while made to protect the population can be regarded [as] conflicting with individual human right [I]t is reasonable to expect, that the deleterious effect of confinement is amplified in this population compared to those living in the community because there are no relatives there, isolation has been greater and, in most homes, both activities and going out have stopped.

Aida Suárez-González et al., *The Effect of Covid-19 Isolation Measures on the Cognition and Mental Health of People Living with Dementia: A Rapid Systematic Review of One Year of Evidence*, MEDRXIV (Mar. 20, 2021), <https://www.medrxiv.org/content/10.1101/2021.03.17.21253805v1.full>; Karako-Eyal, *supra* note 36, at 171 (“There is a growing body of research indicating that chronic loneliness and isolation, especially among elderly people, contributes to a cycle of illness, health care utilization, and decreased wellbeing.”).

¹⁸⁷For example, researchers found that:

Nursing home residents, for example, have been particularly affected by the pandemic, both in terms of elevated risk of infection due to the presence of frailty and multimorbidity, as well as the restrictions on visitations aimed at reducing transmission. A cross-sectional survey found that 6–10 weeks after the introduction of a visitor ban in the Netherlands, high levels of loneliness and depression in residents were reported, as well as exacerbations in mood and behavioural problems

Roger O’Sullivan et al., *Will the Pandemic Reframe Loneliness and Social Isolation?*, 2 THE LANCET e54, e54–e55 (2021) (footnote omitted). See also Levere et al., *supra* note 34, at 949 (“Without face-to-face interactions, many nursing home residents struggle to remain engaged with others. Social isolation and loneliness among older adults have been identified as serious public health concerns that are associated with poor health outcomes, such as depression and cognitive decline as well as physical morbidity and mortality.”); and *id.* at 951 (noting that in nursing homes “depression, incidence of substantial unplanned weight loss, cognitive functioning, and incontinence . . . worsened. The timing of these changes corresponded to the timing of the evolution of the pandemic.”). Indeed:

The nature of the pandemic required immediate and substantial policy actions, such as restricting visitors . . . to limit the number of fatalities. . . . Yet, they may have also been one contributing factor to the reduction in well-being we found, suggesting that policy makers need to consider both the costs and benefits of such policies.

Id. See also Lubaba Dahab et al., *Effect of COVID-19 Pandemic on Depression and Medications Use on Nursing Home Residents*, 22 J. AM. MED. DIRS. ASS’N B20, B20 (2021) (“Data analysis showed a significant increase in nursing home residents diagnosed with depression in 2020.”); *id.* at B21 (“We think the limited socialization, activities, and the change in nursing home visitation policies have an undeniable role in decreasing the threshold for depression in this vulnerable age group.”); SUÁREZ-GONZÁLEZ ET AL., IMPACT OF COVID-19 ON PEOPLE LIVING WITH DEMENTIA, *supra* note 6, at 12 (“Anxiety, depression and overall quality of life may be adversely affected as result of confinement.”); *id.* at 13 (“[M]any people with dementia who were used to having visits and care from family and friends, have stopped receiving these visits. For people living with dementia it may be very hard to understand and remember why their families no longer come to visit and provide care”); Wan, *Pandemic Isolation*, *supra* note 6 (“People with dementia are dying not just from the virus but from the very strategy of isolation that’s supposed to protect them. In recent months, doctors have reported increased falls, pulmonary infections, depression and sudden frailty in patients who had been stable for years.”); Rachel Chason, *A Daughter’s Choice: Her Mom Didn’t Have Covid-19. But Isolation Seemed to be Killing Her*, WASH. POST (Aug. 21, 2020), <https://www.washingtonpost.com/health/2020/09/16/coronavirus-dementia-alzheimers-deaths/> (observing that in congregate residential settings, “the mass shutdown has created a deep social isolation that experts say has contributed to soaring rates of depression and anxiety and general loss of the will to live”); Suárez-González et al., *supra* note 186 (“Lockdowns and confinement measures brought about by the pandemic have damaged the cognitive and psychological health and functional abilities of people with dementia across the world. It is urgent that infection control measures applied to people with dementia are balanced against the principles of non-maleficence.”); AMNESTY INT’L, AS IF EXPENDABLE: THE UK GOVERNMENT’S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC 34–36, 39 (2020) (noting the “devastating consequences” that flowed from visitation restrictions and the reports of those who have “told Amnesty International that many residents have suffered loss of movement, reduced cognitive functions, reduced appetite, and loss of motivation to engage in conversation and other activities which they used to enjoy before lockdown”); and GAO-22-105133, *supra* note 1, at 10 (noting that “seven of the eight key indicators of nursing home resident mental and physical health that we reviewed worsened at least slightly in 2020, the first year of the pandemic Six of these key indicators continued to be worse in the second year” and that two of the most significant

A. Physical and Mental Impact of Visitation Limitations

As is now more fully understood, “[t]he draconian nature of quarantine has resulted in collateral damage in the form of an accelerated decline in nursing home resident’s mental and physical health.”¹⁸⁸ It is hard to imagine such a degree of isolation would be tolerated so long for any other

increases were in the percentages of residents experiencing depression and experiencing “unexplained weight loss”). *But see* Leontjevas et al., *supra* note 20, at 1315–17 (noting that some residents who fully understood the reasons for the restrictions experienced *reduced* stress with fewer family visiting).

¹⁸⁸Saldaris, *supra* note 4, at 314. *See also id.* (“[T]he resulting loneliness so common among the elderly continues to predict poor prognosis for their overall health.”); COMMISSION FINAL REPORT, *supra* note 16, at 32 (“Although visitation restrictions have partially protected the physical health of residents, the practice also has resulted in unintended harm.”); Frampton et al., *supra* note 59, at 1 (“Out of an abundance of caution, widespread restrictions or complete bans on family presence have been implemented in many care settings, yielding substantial negative unintended consequences.”); Giovenco, *supra* note 19 at 128–33 (describing negative impact of loneliness during lockdowns); Colleen Ceh Becvar, *Death By Despair: The Unintended Consequence of Isolation Protocols During COVID-19*, DCBA BRIEF, Nov. 2020, <https://www.dcba.org/mpage/v33-Colleen-Ceh-Becvar> (“There is another sinister, slow growing, less obvious cause of death weaving its way, undetected . . . into the minds, bodies and definitely the spirits of our older adult population. It is despair. And, it’s killing people.”); GAO-22-105133, *supra* note 1, at 13 (noting that experts in the nursing home industry attributed the declines in mental and physical health “in part to the isolation residents felt from the limitations CMS placed on visitation or group activities in nursing homes during the pandemic”); Cerminara et al., *supra* note 4, at 353 (“[V]isits from family and close friends have been found to have several positive health effects on nursing home residents, including higher life satisfaction and increased life expectancy. Increased family involvement has also been found to improve quality of life and influence residents’ psychosocial or functional outcomes.” (footnote omitted)); *id.* at 358 (“Lack of social connection through communal dining and visitation have been linked to failure to thrive.”); *id.* at 359 (“Research demonstrates an association between lack of human contact and a decline in cognitive function”); and *id.* (“Social isolation and loneliness both have been associated with a long list of adverse functional, mental, and physical health outcomes, including increased falls, functional decline, malnutrition, cardiovascular disease, increased depression, and dementia.”).

population¹⁸⁹—with the possible exception of those in prison.¹⁹⁰ Recognizing this, one commentator perceptively referred to nursing homes in the age of COVID-19 as “golden prisons.”¹⁹¹

¹⁸⁹Some have observed:

Negative and prejudicial attitudes towards older people explain why precarious and at times sub-optimal care support for older people has been considered acceptable [C]are homes were left in the shadows for some time during the pandemic This included failing to provide care homes with adequate PPE, access to testing and additional support to replace absent staff. The loss of human lives of older people living in care homes was not treated as a priority and was not even visible until newspapers and researchers across the world commenced publishing grim figures of deaths. . . . [C]onfinement measures. . . . have detrimental effects on the physical, social, cognitive and psychological health of people living with dementia. . . . [T]he requirement to self-isolate and the ban on visits from close family caregivers (including spouses) to care homes; being forced to stay in one’s own room indefinitely . . . may be a violation of their human rights.

See SUÁREZ-GONZÁLEZ ET AL., *IMPACT OF COVID-19 ON PEOPLE LIVING WITH DEMENTIA*, *supra* note 6, at 26–27. However, one commentator noted that, as a broader matter, some of the more generally applicable COVID-19 responses also raised human rights concerns. See generally Kelly Shea Delvac, *Human Rights Abuses in the Enforcement of Coronavirus Security Measures*, *THE NAT’L L. REV.* (May 25, 2020), <https://www.natlawreview.com/article/human-rights-abuses-enforcement-coronavirus-security-measures>. (arguing that draconian COVID quarantines and lockdown orders violate multiple human rights guarantees).

¹⁹⁰For further background on COVID visitation restrictions in prisons, see *How Prisons in Each State Are Restricting Visits Due to Coronavirus*, *THE MARSHALL PROJECT* (Dec. 8, 2021), <https://www.themarshallproject.org/2020/03/17/tracking-prisons-response-to-coronavirus>. See also Nitika Suchdev, *The Unconstitutionality of Access to Health Care in Prisons During COVID-19*, 30 *ANNALS OF HEALTH L. ADVANCE DIRECTIVE* 329 (2020); Abby Higgins, *Compassionate Release During a Pandemic: Clearer Routes for Direct Advocacy of Prisoners to Avoid Harmful Delays to Medically Vulnerable Population*, 30 *ANNALS OF HEALTH L. ADVANCE DIRECTIVE* 199 (2020) (reviewing role of compassionate release programs to provide relief from COVID-19 risk in prisons). In addition, the lack of access to clergy visits for prisoners also received attention and opposition from faith leaders. For example, the Catholic Archdiocese of Milwaukee brought suit against the Wisconsin Department of Corrections for its prohibition of clergy visits to incarcerated persons. See *Complaint, Archdiocese of Milwaukee v. Wis. Dep’t of Corr.*, (Jefferson Cnty. Cir. Ct. May 7, 2021) (Case Code 30701).

¹⁹¹Saldaris, *supra* note 4, at 316. The nursing home-prison analogy is further developed in *id.* at 320–22. See also Cerminara et al., *supra* note 4, at 357 (“[N]ursing home residents might as well have been absolutely isolated in terms of contact and personal connections.”); and *id.* (“[B]ans or later limitations on the number of visits and visitors resulted in a social life comprised exclusively of brief interactions with ghostly figures swathed in personal protective equipment such as gowns, masks, and face shields.”).

Even as isolation's devastating toll became more well known, many restrictions enacted as immediate emergency measures were not lifted for very long periods of time.¹⁹² Indeed, in opposing the lifting of visitation restrictions, the Society for Post-Acute and Long-Term Care Medicine argued:

[W]e urge federal, state and local governments and health authorities to stipulate that, in the chain of events leading to reopening businesses and buildings, that [post-acute and long-term care] facilities, where older adults most at risk of serious illness or death from COVID-19 reside, *be the last to open* to visitors¹⁹³

From an infection-control perspective, this may have been correct. Nevertheless, given the genuine dangers of isolation, vulnerable residents may have had the greatest need for visitors. All too often, temporary restrictions seemed to be en route to becoming a painful, lonely "new normal" for residents of congregate residential settings.¹⁹⁴

¹⁹²This was true of other restrictions as well. For example, in the context of community religious gatherings, one commentator made the analogous observation that:

When the dangers of COVID-19 first became apparent to the American public this past March, few churches resisted state and local lockdown orders that prohibited or severely limited in-person worship services. The potential for congregational gatherings to rapidly spread the virus was widely understood, and most religious believers probably anticipated a relatively short disruption. However, as the pandemic nears its seventh month and many jurisdictions retain substantial restrictions on in-person worship, many Americans are growing increasingly frustrated with limits that impinge upon core religious practices and undermine the spiritual, social and emotional goods that these practices nourish. It is not surprising, then, that litigation over restrictions on in-person worship has been increasing.

Kathleen A. Brady, *COVID-19 and Restrictions on Religious Institutions: Constitutional Implications*, CANOPY F. (Oct. 2, 2020), <https://canopyforum.org/2020/10/02/covid-19-and-restrictions-on-religious-institutions-constitutional-implications/>.

¹⁹³Press Release, The Soc'y for Post-Acute & Long-Term Care Med., *Statement on the Reopening of Post-Acute & Long-Term Care Facilities* (May 6, 2020) (emphasis added).

¹⁹⁴See Julie Storr et al., *Safe Infection Prevention and Control Practices with Compassion—A Positive Legacy of COVID-19*, 49 AM. J. INFECTION CONTROL 407, 407 (2021) (stating the opinion of infection experts that "prohibitions on all visits to such settings that were implemented at the start of the pandemic in the name of infection prevention. In too many instances . . . have remained in place."). In addition:

The harm of ignoring all dangers other than COVID-19 is abundantly clear:

For approximately 2.5 million elderly Americans in long-term care, the threats posed by the coronavirus are twofold: rampant deaths and an unprecedented era of isolation. Visitors were banned at long-term care facilities nationwide in mid-March, and communal dining and activities were mostly canceled. While those changes may have been necessary to slow the spread of the virus, medical experts say they proved devastating for the mental and physical health of residents, particularly the more than 40 percent

The longer the current situation prevails, the more likely it is to become routinized [S]ome homes are considering outdoor heaters to support outdoor “visits” by families in winter and the use of video call technology is becoming an unacceptable “norm.” This is not the answer; these are peoples’ own homes, often at the later stages of their lives

Id. See also *id.* (“[T]here is the very worrying matter of deimplementation to address. Once in place, examples such as outdoor visits and the use of technology to replace face-to-face family interactions become routinized.”); U.N. POLICY BRIEF, *supra* note 7, at 9 (noting that “risks are magnified if such measures remain in place for protracted periods and do not allow for in-person social interactions or other mitigating measures”); and Eefje M. Sizoo et al., *Dilemmas with Restrictive Visiting Policies in Dutch Nursing Homes During the COVID-19 Pandemic: A Qualitative Analysis of an Open-Ended Questionnaire with Elderly Care Physicians*, 21 J. AM. MED. DIRS. ASS’N 1774, 1780 (2020) (noting that among family members, “[a]t first[] they experienced largely understanding for the situation. However, since May [2020], families have increasingly been expressing resistance against the visitor policies.”). Indeed, concerns about quarantine have been raised for the general public—not those with the special needs and vulnerabilities associated with congregate living. A cautionary note has been struck about retaining quarantines longer than necessary. See CTR. FOR THE STUDY OF TRAUMATIC STRESS, PSYCHOLOGICAL EFFECTS OF QUARANTINE DURING THE CORONAVIRUS OUTBREAK: WHAT HEALTHCARE PROVIDERS NEED TO KNOW 2 (n.d.), https://www.cstsonline.org/assets/media/documents/CSTS_FS_Psychological_Effects_Quarantine_During_Coronavirus_Outbreak_Providers.pdf (“[R]estrict the length [of quarantine] to what is scientifically reasonable and take care not to adopt an overly cautious approach. . . . [D]o not extend quarantine length unless absolutely necessary.”). One researcher found:

[L]onger durations of quarantine were associated with poorer mental health specifically, post-traumatic stress symptoms, avoidance behaviours, and anger. Although the duration of the quarantine was not always clear, one study showed that those quarantined for more than 10 days showed significantly higher post-traumatic stress symptoms than those quarantined for less than 10 days.

Samantha K Brooks et al., *The Psychological Impact of Quarantine and How to Reduce It: Rapid Review of the Evidence*, 395 THE LANCET 912, 916 (2020) (footnotes omitted).

who have Alzheimer's or other forms of dementia at such facilities.¹⁹⁵

In addition to the harm these restrictions imposed on residents, they also affected their relatives and friends.¹⁹⁶ Children were denied access to their parents; spouses were separated from each other; and siblings, friends, and others were deprived of each other's support.¹⁹⁷

In a utilitarian, practical sense, these restrictions also reduced the unpaid and often significant care provided by loved ones. This left residents with reduced physical care.¹⁹⁸ It also eliminated the outside oversight of residents'

¹⁹⁵ Chason, *supra* note 187. See also *id.* ("All officials seemed to talk about was stopping the spread of the coronavirus, not otherwise ensuring the health of residents.").

¹⁹⁶ See generally Joost D. Wammes et al., *Evaluating Perspectives of Relatives of Nursing Home Residents on the Nursing Home Visiting Restrictions During the COVID-19 Crisis: A Dutch Cross-Sectional Survey Study*, 21 J. AM. MED. DIRS. ASS'N 1746 (2020) (reviewing results of surveys of the impact of visitation restrictions on relatives of residents in Dutch nursing homes); *id.* at 1749 (indicating that while "both nursing home residents and relatives experienced adverse effects on well-being because of visiting restrictions. . . there was no consensus between relatives of nursing home residents if the adverse effects on well-being outweigh the protective effect against the COVID-19"); *id.* ("[M]ost respondents were concerned the nursing home residents were experiencing loneliness, sadness, and decreased quality of life while respondents themselves were mainly experiencing sadness."); and Paananen et al., *supra* note 186, at 7 (saying of residents' family members that "[t]he challenges they faced in relation to the distancing are reflected in their expressions of guilt. Some of them felt guilty about their absence. Sometimes, too, the guilt derived from feelings of relief: the distancing was beneficial in terms of their own well-being.").

¹⁹⁷ The impact on family members as well as on residents is documented in 167 CONG. REC. H3301-04 (daily ed. June 29, 2021) (describing impact on families and urging passage of the Essential Caregivers Act of 2021).

¹⁹⁸ As one researcher observed:

Visits from family and friends are central to the care of residents, buffering against loneliness, anxiety, and depression by providing continuity, advocacy, and emotional support. Visitors (family members and friends) also assist with personal care. . . . [D]uring this pandemic family caregivers have been recognized as the "invisible workforce" that has provided essential care and alleviated strain on health and social care systems.

See Rónán O'Caomh et al., *Psychosocial Impact of COVID-19 Nursing Home Restrictions on Visitors of Residents with Cognitive Impairment: A Cross-Sectional Study as Part of the Engaging Remotely in Care (ERiC) Project*, FRONTIERS IN PSYCHIATRY, Oct. 2020, at 1, 2 (footnotes omitted); Levere et al., *supra* note 34, at 954 (observing that "limitations on visitors meant that family members and other unpaid caregivers, who normally provide important supplemental care to nursing home residents, could no longer fulfill that role."); Wan, *Pandemic Isolation*, *supra* note 6 (quoting Jason Karlawish who noted "[f]amilies fill in a lot of gaps at nursing homes. They do much of the feeding and bathing. They advocate and communicate"); Tagliabue et al., *supra* note 20, at 7 ("It has been suggested that residents should not be isolated from their loved ones for a long time not only in order to support their social well-being and avoid loneliness, but also because friends and family members often help to provide essential care for residents."); E. Hall et al., *Time*

well-being by loved ones who know them well and notice when decline, neglect, or abuse occur.¹⁹⁹ Indeed:

to Follow the Evidence—Spiritual Care in Health Care, 9 ETHICS, MED. & PUB. HEALTH 45, 47 (2019) (“Families and friends are considered an essential part of the care team.”); Joyce Simard & Ladislav Volicer, *Loneliness and Isolation in Long-Term Care and the COVID-19 Pandemic*, 21 J. AM. MED. DIRS. ASS’N 966, 966 (2020) (“Many family members of . . . residents visit often, sometimes every day, bring food, and help the residents with eating and drinking. If they cannot visit, they may be afraid that the resident will no longer recognize them.”); and Powell et al., *supra* note 20, at 62 (noting that, in nursing homes, visiting family members “provide countless hours of support by feeding and caring for family members.”). Relatedly, the bedside unavailability of family members has also affected professional nursing staffs. Maaskant found:

[V]isiting restrictions caused moral distress and ethical dilemmas to some nurses. Moral distress can be described as the negative experience of psychological imbalance related to a moral dilemma. This may occur when nurses cannot fulfil their moral obligation to a patient, such as delivering the best care possible, or fail to pursue what they believe to be the correct course of action caused by forces that are out of their control.

J.M. Maaskant, *Strict Isolation Requires a Different Approach to the Family of Hospitalised Patients with COVID-19: A Rapid Qualitative Study*, INT’L J. NURSING STUD., May 2021, at 1, 7 (citations omitted). The United States Government Accountability Office’s research showed the same:

Officials from one nursing home said that these residents did not eat as well when being fed by a busy staff member rather than an attentive visitor and thus lost weight. . . . [A]nother . . . said that residents were at a higher risk for falls for various reasons including, for example, they were alone in their rooms and would try to move independently

GAO-22-105133, *supra* note 1, at 13–14. *See also* Cerminara et al., *supra* note 4, at 354 (“In many instances, families assist with grooming or simply touch or hold hands with residents.”); and *id.* at 355 (describing family members’ “role as overseers of the care their loved ones receive and advocates for better communication.”). In addition:

[I]n the catastrophically common scenario of infection control measures that exclude families and isolate residents from others in the home, all strategies rely on a healthy, sustained LTC [long-term care] workforce. Without these vital interactions with famil[ly] and other residents, problems of deteriorating mental health among residents are compounded by already-strained LTC staff who are now further challenged to provide care, including social connection, to residents. LTC homes worldwide must be supported to address problems of chronic understaffing and a workforce crisis in LTC.

Bethell et al., *supra* note 38, at 234 (footnote omitted).

¹⁹⁹*See* AMNESTY INT’L, *supra* note 187, at 34–36 (observing that suspension of visits by friends, family, and others reduced the quality of oversight); Becvar, *supra* note 188 (“At a time when vulnerability was at its greatest, the mechanisms for oversight, protection and giving voice to the vulnerable were nowhere to be found and access was denied.”); *id.* (“[D]irect care . . . workers are oftentimes working more than one (caregiving) job and therefore, literally bringing COVID into the rooms If direct caregivers are known carriers and family members are potential carriers, perhaps we revisit the restrictions imposed on loved one’s visits.”); *id.* (describing the benefits of

[I]nvolvement of [family members] appears to improve the quality of individual care among older adults in nursing homes. [Family members] are sensitive to changes in the health status of their next of kin, which contributes to the timely deliverance of individually planned care. They may support professional care by providing valuable information, and are often able to reduce confusion and agitation Inside the nursing homes they may participate in practical care and rehabilitative activities, and more importantly, they have an irreplaceable role in sustaining the previous relationships and personhood of residents.²⁰⁰

visitation as not merely “feel-good visits” but also “the essential second set of eyes on loved ones, which also bring social stimulation, laughter, familiarity, companionship and love that is indeed life-giving and life-saving to some”); Chason, *supra* note 187 (quoting geriatrician Michael Wasserman who observed, “cases of neglect and other issues have gone unnoticed because when visitors were barred, residents lost their most important watchdogs: families and the local ombudsmen, who are supposed to regularly visit long-term care facilities and investigate complaints”); and Antonisse, *supra* note 3, at 1816 (“[F]amily members and others were barred from entering facilities and thus could not monitor and raise concerns about care quality.”). In addition:

Staffers and residents alike shouldn’t be needlessly exposed to the virus. But neither should someone be cut off from all family contact. . . . [F]amily members can spot troubling signs in residents more quickly than can staff members, who may be rotating through shifts and not well acquainted with certain residents.

Will Englund, *In Some States, Families Can Start Visiting Nursing Homes Again*, WASH. POST (June 27, 2020, 8:23 AM), <https://www.washingtonpost.com/business/2020/06/27/some-states-families-can-start-visiting-nursing-homes-again/>; *Id.* (“[N]ursing homes have been operating without the vigilant oversight that visitors provide.”). Furthermore:

[L]imiting potential exposure to the virus through physical isolation has left family members, legal surrogates, and others unable to observe the status of residents due to restrictive visitation policies. Public input submitted to the Commission expressed fears about, and examples of, abuse and neglect—and missed opportunities to identify or intervene.

COMMISSION FINAL REPORT, *supra* note 16, at 8. GAO-21-402T, *supra* note 14, at 1 (noting that with visitation restrictions, residents “may have less social interaction and third party oversight of their care”); and *id.* at 6 (“The restriction of visitors has created limited oversight of facilities through the exclusion of resident advocates, such as family members and ombudsmen.”). Sadly, the risk of abuse of vulnerable persons spreads far beyond those living in congregate residential settings. *See generally* David Godfrey, *Coronavirus Isolation May Heighten Risk for Elder Abuse*, A.B.A. (Mar. 25, 2020), https://www.americanbar.org/groups/law_aging/resources/coronavirus-update-and-the-elder-law-community/coronavirus-and-elder-abuse/.

²⁰⁰Paananen et al., *supra* note 186 (citations omitted).

Restrictions also engendered the grim reality that an increased number of people—with and without COVID-19—passed from this life utterly alone.²⁰¹ Even if restrictions allowed deathbed visitors through “compassionate care” exceptions, implementation was problematic.²⁰² It was difficult to determine when a person was dying.²⁰³ Even if visitors were allowed, the number might be limited, necessitating painful choices.²⁰⁴ In addition, visitors may arrive after a loved one lost consciousness. Determining when death was sufficiently imminent is an imprecise science at best.²⁰⁵

As evidence mounts as to the lockdowns’ harm, it is imperative that congregate residential settings plan much better to ensure that they do not happen again, and that safeguards to protect residents’ access to their chosen visitors be a necessary part of each institution’s planning and a much more significant requirement for licensure.²⁰⁶ Indeed, it is disappointing that the 198-page *National Strategy for the COVID-19 Response and Pandemic Preparedness*²⁰⁷ pays very little attention to residents of congregate living settings other than acknowledging that they are high risk for COVID-19²⁰⁸ and offering vague guidance.²⁰⁹ The Executive Order *Improving and*

²⁰¹ See generally Peter Strang et al., *Dying from COVID-19: Loneliness, End-of-Life Discussions, and Support for Patients and Their Families in Nursing Homes and Hospitals. A National Register Study*, J. PAIN & SYMPTOM MGMT., Oct. 2020, at e2, e2 (noting, in a survey of Swedish nursing homes and hospitals, that “[m]any patients are dying alone as coronavirus disease 2019 places restrictions on visits. Family members are seldom allowed to say goodbye.”).

²⁰² See Sizoo et al., *supra* note 194.

²⁰³ See *id.* at 1778 (noting that physicians “struggle with the timing to diagnose ‘dying’” since “the dying phase is not always clear”). As a result, “residents with a rapid course of the dying phase [would not be] able to say farewell to their loved ones.” *Id.* Yet “concluding too early that the resident was in a dying phase implies more visitors . . . and may set a precedent for others.” *Id.*; see also *id.* at 1779 (“It is well-known that diagnosing dying is a highly complex process.”).

²⁰⁴ See, e.g., *id.* (noting that “the restriction of 2 visitors implied not all close loved ones . . . could say farewell. For example, it could cause siblings to have to choose who of them could visit their dying parent.”).

²⁰⁵ See *id.* at 1780 (noting that when there is a strict visitation policy in place “making exceptions meddled with protection of and justice for other residents in the institution”).

²⁰⁶ See, e.g., Saldaris, *supra* note 4, at 315–16 (arguing that “executive orders must include failure to thrive (‘FTT’) provisions, which permit an exception to the visitation ban, allowing for a permanently designated family member to be the sole visitor for a nursing home resident and not only at end-of-life situations”). While this is still overly limited, as it does not allow for spiritual care visitations, the crucial point is that visitation should not be delayed until the end of life. *Id.*

²⁰⁷ JOSEPH R. BIDEN, JR., NATIONAL STRATEGY FOR THE COVID-19 RESPONSE AND PANDEMIC PREPAREDNESS (2021), <https://www.whitehouse.gov/wp-content/uploads/2021/01/National-Strategy-for-the-COVID-19-Response-and-Pandemic-Preparedness.pdf>.

²⁰⁸ *Id.* at 105 (indicating COVID-19 risk factors for those in congregate residential settings).

²⁰⁹ *Id.* at 103 (directing HHS and CMS to “strengthen Long Term Care facility guidance, funding, and requirements around infection control policies; support Long Term care staffing levels

*Expanding Access to Care and Treatments for COVID-19*²¹⁰ urged relevant departments and agencies to “provide targeted surge assistance to critical care and long-term care facilities . . . in their efforts to combat the spread of COVID-19.”²¹¹ It would have been very helpful had the Order prioritized safe movement out of social isolation as a discrete priority.

Many have begun to comment on the impact of these restrictions, with proposals and advocacy designed to ensure that residents and their loved ones are not kept apart in such draconian ways when the next crisis arises.²¹² Indeed, some have deemed such isolation a “possible violation of the fundamental rights of nursing home residents during a pandemic (Amnesty International 2020), referring to their rights to family life, equality and humane treatment.”²¹³

B. *Spiritual Impact of Visitation Limitations*

A specific part of suspended visitation that has not garnered the attention it should is the extent to which lockdowns limited residents’ ability to practice their religion or receive spiritual care.²¹⁴ This is particularly ironic since many congregate residential settings were founded by religious communities who understood the importance of spiritual care for those most vulnerable.²¹⁵ Restrictions deprived residents of that care even though

sufficient to ensure patient safety, and support the accelerated distribution of vaccines to residential care settings”).

²¹⁰ Exec. Order No. 13,997, 86 Fed. Reg. 7201 (Jan. 21, 2021).

²¹¹ *Id.*

²¹² See generally SAFE PRACTICES WITH COMPASSION, *supra* note 183 (offering proposed protocol for safe visitation in congregate residential settings).

²¹³ Paananen et al., *supra* note 186, at 3; see also *id.* at 8 (noting that studies “imply that the measures taken to protect the life and health of residents during the COVID-19 outbreak were short-sighted in terms of the social dimension of well-being”).

²¹⁴ One careful discussion of this question was presented early in the pandemic in Harold G. Koenig, *Maintaining Health and Well-Being by Putting Faith Into Action During the COVID-19 Pandemic*, 59 J. RELIGION & HEALTH 2205 (2020). While not specifically geared toward the spiritual needs of residents of congregate residential settings, he nevertheless makes the oft-neglected point that “[f]or many, religious faith is an important resource for health and well-being, one whose effects should not be underestimated.” *Id.* at 2206. See also *id.* at 2207 (“A large and growing volume of research now documents the benefits of religious faith on immune functioning and vulnerability to infection, viral infection in particular . . .”).

²¹⁵ See Jeff Levin, *The Faith Community and the SARS-CoV-2 Outbreak: Part of the Problem or Part of the Solution?*, 59 J. RELIGION & HEALTH 2215, 2215 (2020) (“Religiously sponsored medical care institutions are vital to health care response efforts.”), and

[C]onsider how many medical centers are branded with the words Baptist, Catholic, Methodist, Lutheran, Episcopalian, Presbyterian, Adventist, and so on. . . . [T]hese

“spiritual care is not a luxury, it is a necessity for any system that claims to care for people.”²¹⁶

Studies show the importance of such care to human dignity and holistic well-being.²¹⁷ Access to spiritual care benefits not only the soul but has been

denominations are full partners in the effort to face the challenge of the current outbreak, and are invested in this work as a central feature of their ministries of service.

Id. at 2222

²¹⁶Ferrell et al., *supra* note 26, at e8. *See also* Rocío de Diego-cordero et al., *Spiritual Care in Critically Ill Patients During COVID-19 Pandemic*, 70 NURSING OUTLOOK 64, 64 (2021) (discussing the importance of spiritual care for hospitalized patients during the pandemic and limitations on the ability to provide such care); Clare O’Callaghan et al., *Patients’ and Caregivers’ Contested Perspectives on Spiritual Care for Those Affected by Advanced Illnesses: A Qualitative Descriptive Study*, 58 J. PAIN & SYMPTOM MGMT. 977, 978 (2019) (“Spiritual care is an essential component of compassionate and dignified care of patients and families grappling with advanced illnesses.”).

²¹⁷As noted in Daniel E. Hall, *We Can Do Better: Why Pastoral Care Visitation to Hospitals is Essential, Especially in Times of Crisis*, 59 J. RELIGION & HEALTH 2283, 2284 (2020) (“[I]solation and dis-membering are a source of great suffering for those with disease. Pastoral visitation targets this suffering—not as an ‘effective’ cure, but as a witness to the enduring interdependence of the human condition, restoring the sick person to relationship through the pastoral visitor.”). *See also* Bethel Ann Powers & Nancy M. Watson, *Spiritual Nurture and Support for Nursing Home Residents with Dementia*, 10 DEMENTIA 59, 61 (2011) (“[S]pirituality and religion have been found to comfort persons with a dementia diagnosis, giving strength, providing hope in the possibility of an afterlife, helping with acceptance, and relieving fears and anxiety.”); *id.* at 71 (noting that “[n]urses, CNAs, and clergy” all stressed “the importance of being present physically and in the spirit—touching, holding residents’ hands and offering words of reassurance.”); Fiona Timmins et al., *An Exploration of the Extent of Inclusion of Spirituality and Spiritual Care Concepts in Core Nursing Textbooks*, 35 NURSE EDUC. TODAY 277, 277 (2015); Enric Benito et al., *Development and Validation of a New Tool for the Assessment and Spiritual Care of Palliative Care Patients*, 47 J. PAIN & SYMPTOM MGMT. 1008, 1009 (2014) (“Spirituality has been identified as an important resource for patients that helps them address distress when facing disease.”); Ayal Pierce et al., *Emergency Department Approach to Spirituality Care in the Era of COVID-19*, 46 AM. J. EMERGENCY MED. 765, 765 (2020) (“[A]ddressing the spiritual and psychological needs of patients and families has become critically important during this public health emergency.”); Marcelo Saad & Roberta De Medeiros, *Should Spiritual Care Be Covered by Health Care Insurance and Health Systems?*, J. PAIN & SYMPTOM MGMT., Dec. 2020, at e27 (arguing that because of its great importance, spiritual care should be covered by health insurance as a part of fundamental patient care); C. Doehring, *Using Spiritual Care to Alleviate Religious, Spiritual, and Moral Struggles Arising from Acute Health Crises*, 9 ETHICS, MED. & PUB. HEALTH at 68, 68 (2019) (exploring the intimate connection between medical care and religious and spiritual care); Hall et al., *supra* note 198, at 48 (“[S]tudies consistently demonstrate that there is a positive relationship between spirituality and health and well-being.”); and Elizabeth Johnston Taylor, *During the COVID-19 Pandemic, Should Nurses Offer to Pray with Patients?*, NURSING2020, July 2020, at 42, 43 (noting the importance of prayer as part of holistic whole-person care). In contrast, Bethell reported that there is some divergence in the relevant literature:

Three observational studies tested associations between social connection and religious activities, spirituality, and faith. One reported that, for both African American and white nursing home residents, preference for religious activities and drawing strength from

shown to have a positive impact on emotional²¹⁸ and physical health as well.²¹⁹ For those who are homebound or ill, the personal and in-person nature of spiritual care is critically important.²²⁰ Indeed, “pastoral visitation should be considered essential care—especially at a time of crisis.”²²¹ This care may take the form of pastoral visits by members of the clergy,²²² spiritual counsel, administration of sacraments, and participation in individual rites

faith were associated with higher social engagement. Another showed that religious coping was positively associated with social support. The third study reported that the association between spirituality and social engagement was not statistically significant.

Bethell, *supra* note 38, at 232 (footnotes omitted).

²¹⁸See, e.g., Benito et al., *supra* note 217, at 1009 (“[P]atients suffering spiritually have indicated that their suffering aggravated their physical/emotional symptoms. Spiritual well-being has been clearly shown to be linked with lower levels of anxiety and depression.”). Hall and others reported that:

[A]n increase in spiritual well-being was associated with a decrease in depression, anxiety, fatigue, and an increase in overall quality of life. . . . [P]eople with relatively higher levels of spiritual distress are more likely to have pain, be depressed, be at higher suicide risk, have higher levels of clinically impactful anxiety, and have higher resting heart rates

Hall et al., *supra* note 198, at 48 (footnotes omitted).

²¹⁹See Hall, *supra* note 217, at 2285 (arguing that clergy “should be welcomed as essential partners in providing excellent health care in all its dimensions.”). A comprehensive literature review of 113 articles on the importance of spiritual care in the context of the intensive care unit may be found in Suzan Willemsse et al., *Spiritual Care in the Intensive Care Unit: An Integrative Literature Research*, 57 J. CRITICAL CARE 55, 55. See also Larry VandeCreek & Laurel Burton, *Professional Chaplaincy: Its Role and Importance in Healthcare*, 55 J. PASTORAL CARE 81, 83 (2001) (noting results of research demonstrating link between physical and spiritual well-being, and urging “a more holistic approach to healthcare”); *id.* at 88 (summarizing research indicating that “persons who reported frequent religious involvements were significantly more likely to live longer compared to persons who were involved infrequently”); and *id.* at 89 (“A study of older adults found that more than half reported their religion was the most important resource that helped them cope with illness.”).

²²⁰See, e.g., Kong, *supra* note 34, at 1594–95 (addressing the importance of in-person worship and administration of sacraments); and Virginia T. LeBaron et al., *How Community Clergy Provide Spiritual Care: Toward a Conceptual Framework for Clergy End-of-Life Education*, 51 J. PAIN & SYMPTOM MGMT. 673, 679 (2016) (“Most clergy articulated a sense of privilege in the opportunity to be present and recognized its intangible importance; all agreed presence was a critical dimension of caring for patients facing serious illness.”).

²²¹Hall, *supra* note 217, at 2283.

²²²This does not mean that spiritual care is limited to clergy. As some note, “there is a pastoral role here for all people of faith, not just for ordained clergy or the chaplaincy.” Levin, *supra* note 215, at 2223. Indeed, many congregations have dedicated lay employees or volunteers whose ministry is to care for those who are ill, homebound, or living in congregate residential settings. See also Taylor, *supra* note 217, at 45 (noting the role that nurses might play in praying with patients, particularly when “those who perform the priestly function in America cannot be physically present with those who are hospitalized with COVID-19”).

and rituals in their private homes. This includes circumstances when those homes are not strictly private but are, instead, situated within congregate residential settings.²²³

Clergy visits might be unnecessary for some residents.²²⁴ For some, religious practice is a private matter that does not require the physical presence of others. However, for many, this is not the case. Often, “[c]ommunity faith leaders also have a potentially significant role to play in health care, as they are often the ones who have an ongoing relationship with a patient and family.”²²⁵ While spiritual care may be particularly important at the moment of death,²²⁶ it is also a critically important part of everyday life, particularly for those living in congregate settings who:

²²³An interesting point was raised by Christopher Ogolla, *Does Religion Matter During a Pandemic?*, BERKLEY CTR. FOR RELIGION, PEACE & WORLD AFFS.: BERKLEY F. (June 3, 2020), <https://berkeleycenter.georgetown.edu/responses/does-religion-matter-during-a-pandemic>, who suggested “religious leaders can be allowed to visit people in their homes to conduct religious services. After all, many states allowed gatherings of 10 or less people during the pandemic.” *Id.* This presupposes a greater appreciation of the fact that nursing homes and other congregate living environments are, indeed, homes and not merely healthcare facilities.

²²⁴O’Callaghan and others observed that

[C]ommon spiritual care that North American patients and caregivers received from clergy, health care professionals, and family/friends included help with coping with the illness and with relationships with loved ones or God. Patients also considered spiritual care to include nurses’ offers of prayers, physician inquiries about faith and medical decision-making, and affirmation of beliefs by general staff.

See O’Callaghan et al., *supra* note 216, at 978 (footnote omitted), and Hall et al., *supra* note 198, at 50–51 (explaining the importance of the professional chaplain). *But see* Cynthia B. Cohen et al., *Prayer as Therapy: A Challenge to Both Religious Belief and Professional Ethics*, HASTINGS CTR. REP., May–June 2000, at 40, 41 (describing difficulties that arise when medical professionals engage in spiritual care of patients).

²²⁵Hall et al., *supra* note 198, at 49.

²²⁶See, e.g., Strang et al., *supra* note 201, at e7 (“Dying alone also has a substantial impact on the . . . indicators of a good death. For example, to be in quarantine with extremely limited possibilities to receive visits from psychosocial/existential counselors or from hospital chaplains, results in limited or no existential/spiritual support.”); and Julie Zauzmer Weil, *In Life’s Last Moments, U.S. Clergy Minister to the Sick and Dying Via FaceTime and Zoom*, WASH. POST (Apr. 2, 2020), <https://www.washingtonpost.com/religion/2020/04/02/last-rites-coronavirus-sick-facetime-clergy/> (“[D]ifficult moments, which often call for a religious ritual such as anointing a dying person with oil, or just for a calming and reassuring touch, are especially hard to conduct now, when many hospitals have banned visitors . . .”). Weil quoted Rev. Paul Scalia, a Catholic priest in the Diocese of Arlington, who reflected:

Death is where the rubber meets the road That is where we want the presence of Christ the most. . . . We need Him especially then. That can be the time of the greatest fear and the time of greatest anxiety. We want to make sure Christ is as present as he can be to that person.

- Had close ties to their local religious community prior to COVID-19;
- Live with fear and anxiety—COVID-19 related and otherwise—and benefit from the comfort of spiritual, pastoral care;
- Lack family members and friends, and rely on religious communities for sustenance and support;
- Belong to religious traditions emphasizing sacramental life or physical proximity;
- Have cognitive impairments or difficulty seeing, hearing, or speaking that may make remote interactions less meaningful; or
- Cherish religious traditions that emphasize communal acts of worship.

Visitation rules were confusing with respect to the status of clergy visits²²⁷—a confusion that, while initially understandable,²²⁸ should never have been allowed to continue. Early guidance was unclear as to whether visitors allowed for spiritual care—such as members of the clergy—were to be treated as family and friends, whose visits were curtailed,²²⁹ or if they should be considered in the same light as “essential” medical caregivers who could more freely visit residents.²³⁰ Months into COVID-19, it was reported

Id. In addition:

Spiritual concerns are particularly pressing at the end of life (EOL), and roughly half of all terminally ill patients in the U.S. rely on community-based clergy for spiritual support. Clergy spend an average of 3–4 hours per week visiting the ill and are especially important in meeting the spiritual needs of minority patients.

LeBaron et al., *supra* note 220, at 673 (footnotes omitted). *See also* Melissa J. Bloomer & Stéphane Bouchoucha, *Australian College of Critical Care Nurses and Australasian College for Infection Prevention and Control Position Statement on Facilitating Next-of-Kin Presence for Patients Dying from Coronavirus Disease 2019 (COVID-19) in the Intensive Care Unit*, 34 AUSTRALIAN CRITICAL CARE 132, 132 (2021) (describing the difficulty of separating dying patients from their loved ones due to COVID-19 visitor restrictions).

²²⁷ *See, e.g.*, Hall, *supra* note 217, at 2284 (“[C]lergy were blocked from visiting hospitalized members of their religious communities during the Covid-19 pandemic. Whether intentionally or inadvertently, hospital policies restricting visitors to ‘essential’ staff were interpreted by many—including clergy themselves—to apply to community-based clergy.”) (citation omitted).

²²⁸ *Id.* at 2285 (acknowledging that “[i]n many cases, the restrictive interpretation of the [visitation] policy may be an oversight or unintended consequence of policies created in appropriate haste”).

²²⁹ *See* Diego-cordero et al., *supra* note 216, at 65 (noting, “the family is one of the main pillars for providing spiritual care”).

²³⁰ *See* Powers & Watson, *supra* note 217, at 74 (noting that, in a survey of nursing homes, “[d]ocumentation indicated low prioritization of spiritual care and lack of staff preparedness in this area” while, at the same time “all of these personnel (100%) agreed that persons with dementia could benefit from spiritual care”); *id.* at 75 (noting that “survey results showed near unanimity in the general belief that spiritual support benefited NH residents with dementia. But, there were sparse

that “[v]isitation guidance is currently unclear. CMS and its federal partners have issued directives and guidance pertaining to visitation during the pandemic in multiple documents, making it challenging for nursing homes to meet (and CMS to enforce) federal expectations or leverage evolving flexibility.”²³¹

Early confusion as to what constitutes “compassionate care” visits²³² created the widespread impression that clergy visits and spiritual care could only be provided at the end-of-life and not as a part of the day-to-day care of residents who might be in distress but not near death.²³³

The days of COVID-19 restrictions also demonstrate the underappreciation of spiritual care.²³⁴ Unfortunately, even prior to COVID-19, this may have been the case.²³⁵ It is not merely entertainment or recreation. In the discussion of public religious services—the primary place in which religion and COVID-19 disputes have been litigated outside the congregate

insights regarding specifics about how this occurred and perceived lack of preparation of NH personnel at all levels to provide spiritual care . . .”).

²³¹ COMMISSION FINAL REPORT, *supra* note 16, at 32.

²³² See Diego-cordero et al., *supra* note 216, as well as notes 227–231 and accompanying discussion.

²³³ The analogous situation in hospitals was also addressed. In an early dispute involving access to clergy visits in Maryland and Virginia hospitals, a religious discrimination complaint was resolved in a manner that would allow visitations. See Press Release, U.S. Dep’t Health & Hum. Servs., *OCR Resolves Religious Discrimination Complaints After Maryland and Virginia Hospitals Ensure Patients Can Receive Safe Religious Visitations During COVID-19* (Oct. 20, 2020), <https://public3.pagefreezer.com/content/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2020/10/20/ocr-resolves-religious-discrimination-complaints-after-maryland-and-virginia-hospitals-ensure.html>.

²³⁴ Indeed, the May 2020 U.N. POLICY BRIEF, *supra* note 7, purported to assess COVID-19’s impact on older persons and made a series of recommendations. Yet, the importance of the spiritual life and access to religious support was not mentioned at all. See also Ferrell et al., *supra* note 26, at e7 (“Although there are profound stories of the spiritual care being provided, many clinicians, patients, and families also have been exposed to a health care system that has not fully recognized the commitment to whole-person care . . .”); and Renske Kruizinga et al., *Toward a Fully Fledged Integration of Spiritual Care and Medical Care*, 55 J. PAIN & SYMPTOM MGMT. 1035, 1035 (2018) (“[T]here is still a tendency to underrate or ignore spiritual needs within the biopsychosocial paradigm, and nonmedical input into general health team discussions tend to be undervalued In addition, patients indicate that their spiritual needs are neglected in standard clinical environments.”).

²³⁵ See Timmins et al., *supra* note 217, at 281 (documenting the lack of training on the importance of spirituality in nursing textbooks and as a component of nursing education); Martha L. Henderson, *Spirituality in the Nursing Home*, 99 S. MED. J. 1182 (2006) (noting, long before COVID-19, that “[o]ften nursing home residents are not only limited physically, but they are isolated from their usual emotional, social, and spiritual supports, including family, friends, and clergy”).

residential setting—religious exercises were often not deemed essential.²³⁶ This reflects assumptions that care of the soul is not every bit as essential as care for the body²³⁷ or other physical needs or desires.²³⁸ This lack of emphasis on the importance of spiritual care in the “outside” world may also have shaped the views of those setting policies for congregate residential settings.²³⁹

²³⁶This point was made by commentators in discussions of executive orders that closed houses of worship but allowed activities deemed by the government to be “essential” activities to continue. See, e.g., Caroline Mala Corbin, *Religious Liberty in a Pandemic*, 70 DUKE L.J. ONLINE 1, 15–16 (2020) (observing that some courts have argued that the activities that were allowed to remain when religious gatherings were prohibited “were essential to survival in a way that church is not. For example, people literally cannot live without food, drink, and medicine.” (footnotes omitted)); FAITH, ARTS, CULTURE, ENT., SPORTS & HOTEL COMM., RECOMMENDATIONS TO THE REOPEN DC ADVISORY GROUP STEERING COMMITTEE 3 (2020) [hereinafter REOPEN DC] (declaring that in the nation’s capital, “[h]ouses of worship are not considered essential businesses”); and Justin W. Aimonetti & M. Christian Talley, Note, *Religious Exemptions as Rational Social Policy*, 55 U. RICH. L. REV. ONLINE 25, 26 (2021).

²³⁷Alternatively, as stated by Corbin, *supra* note 236, this designation “arguably embeds a contested value judgment about what is essential to human flourishing. The objecting churches argue houses of worship provide just as essential a service as supermarkets and certainly more essential than liquor stores.” *Id.* at 16 (footnote omitted). See also *id.* at 17 (“[P]eople must nourish their souls as well as their bodies. Indeed, to valorize the physical over the spiritual may not adequately express everyone’s priorities. For some, cultivating their relationship with God provides more benefit than cultivating a garden.”); and Elana Schor, *Are Church Services Considered ‘Essential’? Depends Where You Live*, CHRISTIANITY TODAY (Mar. 24, 2020, 4:11 PM), <https://www.christianitytoday.com/news/2020/march/state-exemptions-church-covid-19-essential-services.html> (discussing conflicting views with respect to whether religious activities are to be deemed “essential” per COVID-19 restrictions).

²³⁸Consider Ogolla, who noted:

What is an essential service is, of course, a matter of interpretation. Grocery stores, supermarkets, gas stations, road construction, hospitals, public transport, utilities, pharmacies, and banks are some of the obvious essential services. But curiously, essential services include pro-wrestling in Florida; topless delivery service in Portland, Oregon; and liquor stores in New York State. Do we as a society want to equate religious services with the food and restaurant industry, pharmacies, or liquor stores as essential services? Reasonable minds may differ about this.

Ogolla, *supra* note 223.

²³⁹Some have commented on the need to better train medical professionals in the importance of the spiritual life of residents and patients. See, e.g., Cristina Teixeira Pinto & Sara Pinto, *From Spiritual Intelligence to Spiritual Care: A Transformative Approach to Holistic Practice*, NURSE EDUC. PRAC., Aug. 2020, at 1, 1 (“Despite the paramount relevance of addressing spirituality as an important part of the holistic approach to patient care, it remains a soft spot for healthcare practitioners worldwide.”); and *id.* (“Even though healthcare professionals realize its importance, attending to such personal matters does not come easy to most. . . . [M]any healthcare practitioners are not confident about addressing spiritual care, yet the spiritual needs of patients and families have a fundamental role in their comfort and recovery.” (citations omitted)).

There have also been numerous statements expressing the belief that in-person spiritual care need not be prioritized since it could be moved online like many other facets of life or certain aspects of physical care.²⁴⁰ There are certainly abundant possibilities for creative and effective uses of technology.²⁴¹ In some contexts, virtual interactions have proved effective at mitigating some of the negative impacts of enforced isolation—including in the spiritual realm.²⁴² However, this should not be a required substitute, and

²⁴⁰ See, e.g., Egan Millard, *Unable to Be With Dying Parishioners Due to Covid-19, Connecticut Priest Gives Last Rites by Phone*, EPISCOPAL NEWS SERV. (Mar. 24, 2020), <https://www.episcopalnewsservice.org/2020/03/24/unable-to-be-with-dying-parishioners-due-to-covid-19-connecticut-priest-gives-last-rites-by-phone/> (interviewing Episcopal priest who was unable to visit dying patients in hospital due to COVID-19 restrictions and prayed the prayers of extreme unction with the dying over FaceTime).

²⁴¹ For example:

While the role of “tele-chaplains” has yet to be fully explored, many chaplains have incorporated electronic communication in other aspects of ministry and, thus, may feel comfortable with this format. In the context of the patient’s critical health status, tele-chaplains could pray remotely with patients and their families, an intervention that has proven to improve the quality of life for patients near death.

Pierce et al., *supra* note 217, at 765 (footnotes omitted). See also Koenig, *supra* note 214, at 2207 (“[P]eople of faith can often congregate ‘virtually’ by participating in services that are now being live streamed.”); Weil, *supra* note 226 (describing clergy adaptation to use of technology to minister remotely); REOPEN DC, *supra* note 236, at 3 (noting that houses of worship “used creative means through social media and the dissemination of sermons via email to reach congregations and parishioners. They have modified traditional outreach such as in-home visits and provided drive-by shared services such as communion, confession and prayer from a safe distance with no physical contact.”); and *id.* at 12 (stating that technological innovations “have allowed houses of worship to broadcast and stream services live, enabling congregations to feel connected and receive much-needed inspiration and encouragement to help soothe souls during COVID-19”). Simard & Volicer noted that:

Group religious services have been discontinued; however, many are now on the Internet or television. The activity staff will have a social history of each resident and will know the resident’s religion. If it would be comforting for the resident, staff can make sure the mass or other religious service is on the resident’s television or iPad.

Simard & Volicer, *supra* note 198, at 967.

²⁴² For example, Curelaru and others have noted that in the context of assisting patients with dementia navigate the social isolation of the COVID-19 era:

[T]echnology is an increasingly popular option for improving social connectedness. Remote connections with family members satisfy the public health recommendation for social distancing by remotely connecting older adults with family and friends via video conferencing and the use of social media . . . [T]echnology is one of the most realistic methods of addressing the increase in isolation for older adults. . . . It is aligned with

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neither the state—nor individual facilities—may substitute their own judgments about the adequacy of remote spiritual care.²⁴³ This is a presumptuous assumption about the nature of religion for many people.²⁴⁴

III. LEGAL RESPONSES TO ISOLATION IN CONGREGATE RESIDENTIAL SETTINGS

Since the initial, draconian visitation restrictions were imposed, there have been revisions to these restrictions and legislative proposals or enactments to address the isolation that resulted. A brief overview of selected responses is helpful to see the range of approaches, understand the limitations on them, and demonstrate the need for a comprehensive approach to ensure visitation should future health emergencies arise. This is not a full catalog of responses but rather an illustrative selection of approaches that offer guidance for reform.

personal values focusing on social connectedness and was found to be a promising intervention that increases social interaction and decreases loneliness and depression.

Curelaru et al., *supra* note 6, at 951 (footnotes omitted).

²⁴³ See Kong, *supra* note 34, at 1626–28 (“[T]he presumption of viable substitutes for worship undermines the churches’ right to determine its form of worship based on sincerely held beliefs. To presume the validity of these substitutes is a misconception of the sincere, religious basis for in-person worship.”).

²⁴⁴ See Corbin, *supra* note 236, at 17 (“[G]athering in person to worship may not be necessary in the way that heading to the market is. That is, there may be no other way to procure an exempted essential service but to physically go somewhere in person, while alternatives exist for religious services.”). Furthermore,

For those who must worship, alternatives to in-church services abound. People may pray to God on their own at home or together outside, online, or at drive-in services. . . . To be sure, the experience is not exactly the same . . . but little in our lives today is exactly the same.

Id. at 17–18 (footnotes omitted). See also Kruijinga et al., *supra* note 234, at 1036 (“[S]piritual care is more concerned with being present to and accompanying the patient in their suffering helping them find peace . . .”). In addition,

Certain worship services require face-to-face interactions. Other worship services do not require face-to-face interactions. For example, a holy communion cannot be delivered over email. The Jewish mourner’s prayer . . . requires a quorum of ten people in person to recite; a breakout room would not suffice. Moreover, certain sects cannot use electricity on days of prayers. Zoom is not an alternative for Orthodox Jews.

Blackman, *supra* note 12, at 695.

A. *Ad Hoc Remedies*

In some jurisdictions, greater visitation was achieved simply by allowing restrictions to expire or by ending them with the same types of executive orders or emergency declarations that imposed them. Often, these ad hoc remedies either took place in response to loosened CMS or CDC guidance or after the spread slowed considerably within the state.²⁴⁵

For example, Delaware developed guidelines in the form of a *COVID-19 Updated Re-Opening Plan in Long Term Care Facilities* rather than a statute.²⁴⁶ This plan allowed designation of a support person for residents.²⁴⁷ However, such designations were “at the sole discretion of the . . . facility administrator,” and there were many restrictions on the access the support person would have to the resident.²⁴⁸ Helpfully, this guidance did designate clergy as “health care workers” who must be allowed into facilities absent exposure or symptoms of COVID-19,²⁴⁹ and “compassionate care” visits were to be allowed at all times.²⁵⁰ The guidelines expanded “compassionate care” beyond end-of-life scenarios to include residents struggling with a change in residence, bereavement, required assistance in eating or drinking, and emotional distress.²⁵¹ This expanded access to visitation, but in a limited and ad hoc way.

In other jurisdictions, the strategy was to broaden exceptions to the existing restrictions. Some expanded “compassionate care” visitation to

²⁴⁵ The examples below are not intended to offer an exhaustive analysis of these measures but, rather, as illustrative case studies of typical measures undertaken as COVID-19 waned.

²⁴⁶ DEL. DEP'T OF HEALTH & SOC. SERVS., COVID-19 UPDATED RE-OPENING PLAN IN LONG TERM CARE FACILITIES (2021), <https://coronavirus.delaware.gov/wp-content/uploads/sites/177/2021/03/3-17-21-Reopening-Plan-3-17-21.pdf>.

²⁴⁷ *Id.* at 1.

²⁴⁸ *Id.* at 7. For example, the maximum visitation allowed per day was four hours and must be scheduled in advance. *Id.* There could also be limits on the total number of such support personnel allowed in the building at the same time, and the support person would have to be someone who had provided support to the resident prior to the health emergency at least once a week. *Id.*

²⁴⁹ *Id.* at 2–3.

²⁵⁰ *Id.* at 5.

²⁵¹ *Id.*

scenarios beyond end-of-life. For example, Iowa,²⁵² Kansas,²⁵³ and New Jersey²⁵⁴ and took this approach in their later emergency orders and guidance.

Others began to allow “essential caregiver” visits, even when more widespread visitation was still banned. In Missouri, for example, September 22, 2020, guidance defined “essential caregiver” as “an individual, including clergy members, who has been given consent by the resident, or their guardian or legal representative, to provide health care services or assistance with activities of daily living to help maintain or improve the quality of care or quality of life.”²⁵⁵ While Missouri limited “essential caregivers” to one for each resident, it specified that “[o]ne (1) additional Essential Caregiver may be designated if that individual is a clergy member.”²⁵⁶ Other states such as Minnesota,²⁵⁷ Nebraska,²⁵⁸ and Tennessee,²⁵⁹ also focused their emergency orders, regulations and guidelines on creating more robust essential caregiver programs that allowed a limited number of pre-selected visitors for residents.

Some newly adopted orders or guidelines included greater recognition of clergy and spiritual care providers as part of the care team for residents of congregate residential settings.²⁶⁰ Several designated clergy members as possible “essential caregivers.”²⁶¹ Some jurisdictions did recognize the harm

²⁵² See generally IOWA DEP’T OF INSPECTION & APPEALS, LONG TERM CARE VISITATION GUIDANCE (2021), <https://idph.iowa.gov/Portals/1/userfiles/61/covid19/LTC/LTC%20Visitation%20Guidance.pdf>.

²⁵³ See generally KAN. DEP’T FOR AGING & DISABILITY SERVS., VISITATION GUIDANCE FOR LONG TERM CARE SETTINGS (2021), https://kdads.ks.gov/docs/librariesprovider17/covid-19/hoc/archived-documents/visitation-guidance-for-long-term-care-settings.pdf?sfvrsn=cdbc01ee_2.

²⁵⁴ See generally N.J. DEP’T OF HEALTH, EXECUTIVE DIRECTIVE NO. 20-026: DIRECTIVE FOR THE RESUMPTION OF SERVICES IN ALL LONG-TERM CARE FACILITIES (2020), https://www.state.nj.us/health/legal/covid19/8-20_ExecutiveDirectiveNo20-026_LTCResumption_of_Svcs.pdf.

²⁵⁵ MO. DEP’T OF HEALTH & SENIOR SERVS., *supra* note 170, at 4.

²⁵⁶ *Id.*

²⁵⁷ See generally MINN. DEP’T OF HEALTH, ESSENTIAL CAREGIVER GUIDANCE FOR LONG-TERM CARE FACILITIES (2021), <https://web.archive.org/web/20220123154730/https://www.health.state.mn.us/diseases/coronavirus/hcp/ltccaregiver.pdf>.

²⁵⁸ See generally Gov. Ricketts Announces Shortened Quarantines, Guidance for Essential Caregiver Visitation in Long-Term Care Facilities, NEB. DEP’T OF HEALTH & HUM. SERVS. (Dec. 4, 2020), <https://dhhs.ne.gov/Pages/Gov-Ricketts-Announces-Shortened-Quarantines-Guidance-for-Essential-Caregiver-Visitation-in-LTC-Facilities.aspx>.

²⁵⁹ See generally Tennessee Launches New Initiatives for Long-Term Care Facility Residents, TENN. DEP’T OF HEALTH (Sept. 17, 2020, 2:00 PM), <https://www.tn.gov/health/news/2020/9/17/tennessee-launches-new-initiatives-for-long-term-care-facility-residents.html>.

²⁶⁰ See, e.g., MO. DEP’T OF HEALTH & SENIOR SERVS., *supra* note 170, at 4.

²⁶¹ See, e.g., *id.*

of social isolation, generally, and/or the critical importance of religious practice and spirituality, more specifically.²⁶² Thus, a number of jurisdictions responded in more definitive ways to protect access to visitation, spiritual care, or both in times of future crisis.

However, too many responses such as these were haphazard, easily revocable, and often viewed in a narrow way.²⁶³ Many were in the reactive form of simply relaxing executive orders rather than proactive, prospective legislation that could more reliably ensure short and long-term protection for those in congregate residential settings.²⁶⁴

Other states like Colorado, however, offer examples of how states may strengthen these ad hoc remedies. On October 11, 2022, Colorado ordered that “facilities must allow for visitation at all times for all residents, regardless of vaccination status.”²⁶⁵ Furthermore, “religious services” were explicitly allowed within the facilities, along with compassionate care visitation from designated support persons.²⁶⁶ This applied to a range of congregate residential settings including nursing homes, group homes, and assisted living facilities. Initially, this had the unfortunate ad hoc nature of a public health order easily amended. However, as discussed below, Colorado supplemented this with the greater security of formal legislation. Alas, not every state followed this trajectory.

²⁶² See, e.g., TENN. DEP’T OF HEALTH, *supra* note 259.

²⁶³ This is not true only of the orders issued by various jurisdictions in the United States. For example, experts in the United Kingdom have responded similarly.

Remove any statements that may be seen to justify “blanket bans” on visiting. Instead actively vocalize the need for local decision makers to facilitate safe, normal interaction, appropriate to the local situation. Even where an outbreak occurs and some restrictions may be warranted, make it clear that safe, compassionate exemptions must still prevail and be actively facilitated. Continue to address gaps in safe practices and lack of resources, in order to facilitate infection prevention and control.

See *Open Letter*, *supra* note 44.

²⁶⁴ See, e.g., MICH. DEP’T HEALTH & HUM. SERVS., EMERGENCY ORDER UNDER MCL 333.2253 – EXCEPTIONS TO TEMPORARY RESTRICTIONS ON ENTRY INTO RESIDENTIAL CARE FACILITIES (2020), https://www.michigan.gov/documents/coronavirus/MDHHS_Epidemic_order_nursing_home_visitation_695378_7.pdf.

²⁶⁵ COLO. DEP’T OF PUB. HEALTH & ENV’T, NINTH AMENDED PUBLIC HEALTH ORDER 20-20 REQUIREMENTS FOR COLORADO SKILLED NURSING FACILITIES, ASSISTED LIVING RESIDENCES, INTERMEDIATE CARE FACILITIES, AND GROUP HOMES FOR COVID-19 PREVENTION AND RESPONSE (2022).

²⁶⁶ *Id.*

B. Proposed Federal Legislation

On the federal level, The Essential Caregivers Act of 2021 was proposed in the House of Representatives on June 4, 2021.²⁶⁷ If passed, it would have amended the Social Security Act to require a range of congregate residential settings²⁶⁸ to allow residents to designate up to two “essential care givers” to assist the resident “for 12 hours every day (or, in the case such care is end-of-life care, for an unlimited number of hours every day).”²⁶⁹ The proposed statute defines essential caregivers as those who “will provide assistance consisting of activities of daily living, emotional support, or companionship.”²⁷⁰ Disappointingly, spiritual care is not listed as an activity within the scope of “essential.” Although “emotional support” or “companionship” should be broad enough to include clergy and providers of spiritual support, this is a missed opportunity to state clearly the special importance of such care. The Essential Caregivers Act, if passed, would have required caregivers to comply with the same safety protocols that are asked of the facility’s staff.²⁷¹

A second bill, the Facilitating Virtual Visitation for Nursing Home Residents Act of 2021²⁷² was also proposed to enhance virtual visitation options for those in nursing homes. While this could have value, if passed it covers only nursing homes and has all the inherent limitations in virtual visitation.²⁷³

No action has been taken on the federal legislation. Moreover, it would not include most assisted living situations. Some state initiatives have been more promising.²⁷⁴

²⁶⁷The Essential Caregivers Act of 2021, H.R. 3733, 117th Cong. (2021); *see also* Press Release, Claudia Tenney, Representative, U.S. House of Representatives, Representatives Tenney and Larson Introduce Updated Bipartisan Essential Caregivers Act (June 15, 2021) (<https://tenney.house.gov/media/press-releases/representatives-tenney-and-larson-introduce-updated-bipartisan-essential>) (providing additional information about the Act).

²⁶⁸H.R. 3733 § 2 (noting that these provisions could apply to a “skilled nursing facility,” “nursing facility,” “inpatient rehabilitation facility,” or “intermediate care facility for the intellectually disabled”).

²⁶⁹*Id.* § 3(a)(2).

²⁷⁰*Id.* § 3(a)(2).

²⁷¹*Id.*

²⁷²Facilitating Virtual Visitation for Nursing Home Residents Act of 2021, H.R. 727, 117th Cong. (2021).

²⁷³For further analysis of this Act and a discussion of virtual visitation more broadly, *see generally* Cerminara et al., *supra* note 4, at 365–69.

²⁷⁴*See generally* Stephanie Colombini, *New Laws Let Visitors See Loved Ones in Health Care Facilities, Even in an Outbreak*, NPR (Apr. 3, 2022, 7:00 AM), <https://www.npr.org/sections/health-shots/2022/04/03/1086216581/visiting-patients-during-covid>.

C. State Constitutional Provisions

Texas chose to address visitation rights as a matter of state constitutional law. Texas Proposition 6, a Right to Designated Essential Caregiver Amendment, was on the 2021 Texas ballot and passed. This amendment to Article I of the Texas Constitution now provides:

A resident of a nursing facility, assisted living facility, intermediate care facility for individuals with an intellectual disability, residence providing home and community-based services, or state supported living center . . . has the right to designate an essential caregiver with whom the facility, residence, or center may not prohibit in-person visitation.²⁷⁵

This proposal does not specifically address spiritual care providers such as clergy, but it would not prohibit a resident from naming such a person as the “essential caregiver.”

D. Selected State Statutes and Legislative Proposals

States have taken a range of legislative paths to address the social isolation imposed, and a number have adopted or are considering statutes of diverse types. Some of the most common approaches are discussed below to offer a snapshot of possible alternatives. Again, this is by no means an exhaustive list of state proposals but, rather, a menu of potential options. Some states adopted more than one of these approaches in multi-faceted legislative reforms.

1. Expanding the Definition of “Compassionate Care”

One popular statutory approach was to keep the general existing framework in place but clarify the definition of “compassionate care” so that it could apply to situations where death was not imminent but the distress of the resident would still warrant a greater opportunity for visitation.

Indiana amended its code applicable to visitation in a number of settings.²⁷⁶ In health facilities and residential care facilities, it allowed visitation by family members, legal representatives, clergy, or essential family caregivers in compassionate care situations, without limitations

²⁷⁵TEX. CONST. art. I, § 35(a). This provision goes on to say that the Texas legislature “may provide guidelines [for congregate residential settings] to follow in establishing essential caregiver visitation policies and procedures.” *Id.* § 35(b).

²⁷⁶S. 202, 122nd Gen. Assemb., 1st Reg. Sess. (Ind. 2021) (enacted).

implemented by the facility.²⁷⁷ Compassionate care situation was defined broadly to include end-of-life, bereavement, need for assistance in eating and drinking, and emotional distress.²⁷⁸ In addition, a diagnosis of Alzheimer's disease, other dementia, or a general "failing to thrive" would constitute compassionate care situations.²⁷⁹ This seems to be quite inclusive, and it specifically protects clergy visits. However, there are some notable limitations. For example, it indicates that these visits shall be "in accordance with guidelines from the Centers for Medicare and Medicaid Services."²⁸⁰ As was painfully obvious during COVID-19, it was precisely the CMS guidance that justified some of the most stringent restrictions.

Arkansas law helpfully expanded the definition of "compassionate care visitation" beyond end-of-life situations—an approach taken by other states as well. It included visits that were necessary in circumstances of "physical or mental distress," such as difficulty adjusting to a new residence, bereavement, difficulty eating and drinking, and "social support after frequent crying, distress, or depression."²⁸¹ It did not limit these compassionate care visits only to those who were disabled or hospitalized.²⁸² They are allowed without limitations, and these categories appear flexible enough to allow such visits in a broad range of, admittedly subjective, circumstances.

Florida's statute also adopts a more expansive list of specific scenarios in which visitation must be allowed.²⁸³ This includes end-of-life care and other typical expansions of compassionate care to include struggles with a new residence, emotional distress, bereavement, and the need for assistance in eating and drinking.²⁸⁴ It also requires visitation for labor and delivery, for pediatric patients, and for anyone who is making a "major medical decision."²⁸⁵

Colorado also adopted a broader view of "compassionate care" in its Elizabeth's No Patient or Resident Left Alone Act of 2022.²⁸⁶ It included the traditional end-of-life situations. However, it also included visitation rights

²⁷⁷ *Id.*, sec. 3, § 15.7(b).

²⁷⁸ *Id.*, sec. 3, § 15.7(c).

²⁷⁹ *Id.*, sec. 4, § 12(b)(6)–(7).

²⁸⁰ *Id.*, sec. 4, § 12(b).

²⁸¹ ARK. CODE § 20-6-403(1)(A).

²⁸² *Id.*

²⁸³ FLA. STAT. § 408.823(2)(c).

²⁸⁴ *Id.* § 408.823(2)(c)(1), (2), (4), (5).

²⁸⁵ *Id.* § 408.823(2)(c)(3), (7), (8).

²⁸⁶ S.B. 22-053, 73d Gen. Assemb., Reg. Sess. (Colo. 2022) (enacted); COLO. REV. STAT. § 25-3-125 (2022).

for those “exhibiting signs of physical or mental distress, including: . . . support after moving to a new facility or environment;. . . support after the loss of a friend or family member;. . . support after eating or drinking issues, including weight loss or dehydration”²⁸⁷ It also specifically noted that a visit from “a clergy member or layperson offering religious or spiritual support” would count as a “compassionate care visit.”²⁸⁸

2. Allowing the Designation of “Essential Care Partners”

Another popular strategy was to recognize that general visitor restrictions could be imposed, but that residents should be able to designate a small subset of visitors in advance who could be allowed greater access to visitation because they provided essential care to the resident. States varied in their expectations for what such visitors would do, how many would be permitted, and how they could be designated.

Indiana, for example, had some of the most restrictive rules for “essential care partners” in an effort to ensure that casual visitors were not included. Indiana’s “essential family caregivers” are narrowly construed. They must apply, they must have cared for the resident an average of twice a week before the designation, and the administration of the facility “[s]hall have the discretion to determine whether to designate a person to be an essential family caregiver for a resident.”²⁸⁹

North Carolina enacted Clifford’s Law, which allowed residents to identify one visitor (and an alternate) who would still be allowed to visit twice a month in the event of a declared disaster or emergency.²⁹⁰ The limited number of visits makes this significantly narrower than the approaches of other jurisdictions.

Connecticut passed An Act Concerning Essential Support Persons and a State-Wide Visitation Policy for Residents of Long-Term Care Facilities.²⁹¹ This statute would allow each resident of such facilities to designate one “primary essential support person” with a backup “secondary essential

²⁸⁷ COLO. REV. STAT. § 25-3-125(5)(d)(I) (2022).

²⁸⁸ *Id.* § 25-3-125(5)(d)(II).

²⁸⁹ S. 202, 122nd Gen. Assemb., 1st Reg. Sess., Sec. 5, § 3(b)–(c), 4 (Ind. 2021) (enacted); IND. CODE § 16-28-6.5-3 (2022).

²⁹⁰ Clifford’s Law, H.B. 351, 2021 Gen. Assemb., Sec. 2(a), § 131E-112.5(b)(1) (N.C. 2021); N.C. GEN. STAT. § 131E-112.5(b)(1) (2022).

²⁹¹ H.B. 6634, 2021 Gen. Assemb. (Conn. 2021). Connecticut also commissioned an extensive early inquiry into the impact of COVID-19 in the state. *See* MATHEMATICA, INC., A STUDY OF THE COVID-19 OUTBREAK AND RESPONSE IN CONNECTICUT LONG-TERM CARE FACILITIES: FINAL REPORT (2020), <https://portal.ct.gov/-/media/Coronavirus/20201001-Mathematica-final-report.pdf>.

support person” if the primary is unavailable.²⁹² This essential care person would, in theory, be allowed even when other visitors were barred so that they could provide “assistance with activities of daily living” and “physical, emotional, psychological and socialization support.”²⁹³ This offers more protection from isolation than previously existed. Nevertheless, spiritual care is not mentioned. In addition, the approach is quite clinical, noting that the visitation’s purpose is to provide necessary assistance as “reflected in the resident’s person-centered plan of care.”²⁹⁴ This places a burden on the resident to ensure that the need for visitation is reflected in his or her plan of care upon entry into the residence so that there is documentation that visitation is to be deemed essential. It would also allow essential support person visits to be curtailed in the event of a public health emergency.²⁹⁵

Colorado also included the ability to designate a support person as part of its Elizabeth’s No Patient or Resident Left Alone Act.²⁹⁶ However, the statute also placed some significant limitations on those visitors in times of emergency and indicated that their visits may not be contrary to applicable federal laws—a compelling reason why federal action is essential.

New York’s legislature amended its health law and social services law with similar provisions applying to residents of nursing homes and adult care facilities.²⁹⁷ The amendment would allow up to two “personal caregiving visitors” per resident.²⁹⁸ However, this is subject to a provision that this “may include in appropriate circumstances requiring a physical or mental health professional to state that the personal caregiving will substantially benefit the resident’s mental, physical, or social well-being.”²⁹⁹ This could be a bar to visitation if the need is not deemed “substantial”; the desire for “mere” companionship might not meet this standard. In addition, while the amendment also allows for compassionate care visits, these seem to be in a

²⁹²H.B. 6634 § 1(b), 2021 Gen. Assemb. (Conn. 2021). Long-term care facilities include nursing homes and other “managed residential communities.” *Id.* § 1(a).

²⁹³*Id.* § 1(a).

²⁹⁴*Id.*

²⁹⁵*Id.* § 1(b).

²⁹⁶S.B. 22-053, 73d Gen. Assemb., Reg. Sess. (Colo. 2022) (enacted); COLO. REV. STAT. § 25-3-125 (2022).

²⁹⁷S.B. 614B, 2021–2022 Leg., Reg. Sess. (N.Y. 2021) (enacted).

²⁹⁸N.Y. PUB. HEALTH LAW § 2801-h(2) (pertaining to nursing homes); N.Y. SOC. SERV. LAW § 461-u(2)(d). The act defines “personal caregiving visitor” as “a family member, close friend, or legal guardian of a resident designated by such resident or such resident’s lawful representative to provide personal caregiving for such resident, including a compassionate caregiving visitor.” S.B. 614B, 2021–2022 Leg., Reg. Sess. (N.Y. 2021) (enacted). *Id.* sec. 1, § 2801-h(1)(a); *id.* sec. 2, § 461-u(1)(a).

²⁹⁹*Id.* sec. 1, § 2801-h(2)(b); *id.* sec. 2, § 461-u(2)(b).

narrower set of circumstances than many other states.³⁰⁰ Visits by clergy or for spiritual care are not addressed. There is also very open-ended language that would allow visits to be “temporarily limited or suspended [in circumstances including but not limited to] local infection rates, temporary inadequate staff capacity, or an acute emergency situation.”³⁰¹ This could become an exception that could engulf the rule.

Arkansas’s approach, in the No Patient Left Alone Act, expanded the access of persons with disabilities and minors to have up to three support persons present with them in “a hospital, office of a healthcare professional, or hospice” during public health emergencies that would restrict visitation for others.³⁰² It also expanded visitation in the context of hospice care.³⁰³ This would not, however, assist those who are in congregate residential settings and those without disabilities.

Idaho passed an “essential caregivers” provision to its statute codifying “the right to visitation from an essential caregiver while receiving assistance or health care services at a facility, even if other visitors are excluded by the facility.”³⁰⁴ It requires the essential caregiver to follow safety protocols in the facility and authorizes the facility to “place reasonable restrictions as to where and when the essential caregiver may visit.”³⁰⁵ The legislation is, however, unfortunately vague as to what might trigger those restrictions and whether they might rise to the level of a complete ban.

Pennsylvania has passed an Access to Congregate Care Facilities Act to protect the rights of residents in a range of congregate residential settings—including long-term care nursing facilities, skilled nursing facilities, assisted living facilities, personal care homes, and various facilities for persons with intellectual disabilities—to designate an “essential caregiver.”³⁰⁶ Unlike

³⁰⁰ See *id.* sec. 1, § 2801-h(1)(d) (narrowly defining compassionate caregiving for nursing homes to be that “provided in anticipation of the end of a resident’s life or in the instance of significant mental or social decline or crisis”); *id.* sec. 2, § 461-u (2)(d) (defining the same for adult care facilities).

³⁰¹ See *id.* sec. 1, § 2801-h(2)(f); *id.* sec. 2, § 461-u(2)(f).

³⁰² ARK. CODE § 20-6-404(a) (2021). For commentary on this statute, see ‘No Patient Left Alone Act’ Signed into Law in Arkansas, KATV (Mar. 11, 2021, 3:43 PM), <https://katv.com/news/local/no-patient-left-alone-act-signed-into-law-in-arkansas> and Cerminara et al., *supra* note 4, at 364.

³⁰³ ARK. CODE § 20-6-406(a).

³⁰⁴ S.B. 1353, sec. 1, § 39-9703(1), 66th Leg., 2d Reg. Sess. (Idaho 2022) (enacted).

³⁰⁵ *Id.*

³⁰⁶ 35 PA. STAT. § 10283. The act defines “essential caregiver” as “[a]n individual, whether a family member or friend of a resident of a congregate care facility, who is designated by the resident or appointed by an individual with decision-making authority for the resident to provide physical or emotional support to the resident during a declaration of disaster emergency.” *Id.* § 10282.

some state proposals that specify the tasks that essential caregivers must perform, Pennsylvania's approach is broader, stating only that the person "provide in-person physical or emotional support."³⁰⁷ However, the statute does not provide for clergy visits. In addition, it allows a forty-five-day lockdown period at the start of the declared emergency in which essential caregivers would not be permitted while facilities established their safety protocols.³⁰⁸

Florida passed a No Patient Left Alone Act that establishes a right to in-person visitation in a range of congregate residential settings, including developmental disabilities centers, hospitals, nursing homes, hospices, intermediate care facilities, and assisted living facilities.³⁰⁹ A resident may designate a single essential caregiver who must be allowed two hours of visitation daily.³¹⁰ Interestingly, the statute takes a less clinical approach to the essential caregiver role, noting that the statute "does not require an essential caregiver to provide necessary care . . . and providers may not require an essential caregiver to provide such care."³¹¹ Disappointingly, the statute does not mention spiritual care or clergy visits. While it does require visitors to follow the residence's safety protocols, it notes that these cannot be more stringent than the ones that bind staff members.³¹² It also prohibits imposing vaccination requirements or social distancing requirements for visitors.³¹³

North Dakota passed legislation allowing those living in long-term care facilities to designate "one or more individuals" to be essential caregivers.³¹⁴ While in many respects—such as requirements to follow safety protocols—this statute is typical, it appears to have no cap on the number of "essential caregivers" who can be designated.³¹⁵ It broadly describes them as those who provide "in-person physical, spiritual, or emotional support."³¹⁶

³⁰⁷ *Id.* § 10283.

³⁰⁸ *Id.* § 10283(3).

³⁰⁹ FLA. STAT. § 408.823(1), (2)(a)–(c). For more analysis of the COVID-19 response in Florida, see generally Cerminara et al., *supra* note 4.

³¹⁰ FLA. STAT. § 408.823(2)(b).

³¹¹ *Id.*

³¹² *Id.* § 408.823(2)(a).

³¹³ *Id.*

³¹⁴ N.D. CENT. CODE § 50-10.3-03(1). For additional background on this statute, see generally Adam Willis, *North Dakota Bill Considers 'Designated Caregivers' to Remedy Tight Pandemic Visitation Policies in Nursing Homes*, THE DICKINSON PRESS (Jan. 8, 2021, 5:00 PM), <https://www.thedickinsonpress.com/news/north-dakota-bill-considers-designated-caregivers-to-remedy-tight-pandemic-visitation-policies-in-nursing-homes>.

³¹⁵ See N.D. CENT. CODE § 50-10.3-03(1).

³¹⁶ *Id.* § 50-10.3-01(3).

3. Incorporating Federal Rules by Reference

Some states incorporated federal regulations into their new visitation policies. Alabama, for example, passed the very limited Harold Sachs Act, which applied to residents in any “hospital, long-term care facility, skilled nursing facility, intermediate care facility, assisted living facility, or specialty care assisted living facility.”³¹⁷ This statute merely required that facilities continue to allow visitation “consistent with all applicable federal laws, regulations, and guidelines of the [CMS] or [CDC], or any limitations set by a state or federal public health order.”³¹⁸ Although this would prevent facilities from imposing restrictions on visitation beyond the legal limits, it was precisely those legal limitations that created much isolation. This statute did expand protections to ensure that family, caregivers, and clergy would be allowed, at all times, in end-of-life situations, or if necessary to support residents with disabilities or minors.³¹⁹ However, because this statute incorporates by reference the restrictive rules that created much of the isolation, it is among the least expansive.

4. Explicit Reference to Clergy Visits

Arkansas explicitly recognized the importance of spiritual care by noting that “[a] clergy member or lay person offering religious or spiritual support may be physically present with a patient to pray with or offer spiritual support.”³²⁰ This applies to anyone living in a “long-term care facility” which would include congregate residential settings as diverse as nursing homes, residential care facilities, and intermediate care facilities for individuals with developmental disabilities and, explicitly, assisted living facilities.³²¹

In Louisiana, a bill has been enacted that specifically addresses clergy visits.³²² The statute states that its first purpose is “to protect the religious

³¹⁷ ALA. CODE § 22-21-432(1). For additional background on this statute, see generally Mary Sell, *Lawmaker: During Pandemic ‘Compassionate Care’ Needed in Health Facility Visitor Policies*, ALA. DAILY NEWS (March 8, 2021), <https://www.aldailynews.com/lawmaker-during-pandemic-compassionate-care-needed-in-health-facility-visitor-policies/>.

³¹⁸ *Id.* § 22-21-433(a).

³¹⁹ *See id.* § 22-21-435.

³²⁰ ARK. CODE § 20-6-408.

³²¹ *Id.* § 20-6-403(4). This right would also apply to those in hospitals.

³²² S.B. 12, 2020 Leg., 2d Extraordinary Sess. (La. 2020); LA. STAT. § 40:2005.1. For commentary on this legislation, see generally Melinda Deslatte, *Louisiana Bill Would Ensure Clergy Visits Happen in Pandemic*, AP NEWS (Oct. 13, 2020), <https://apnews.com/article/virus-outbreak-pandemics-public-health-legislation-assisted-living-83e247451af80f49655936adbba8be5c>.

liberty of each patient or resident.”³²³ In light of this, the statute directs the Louisiana Department of Health to “require inpatient health care facilities to allow members of the clergy to visit . . . during a public health emergency whenever a patient or resident requests such a visit. Special consideration shall be given to patients or residents receiving end-of-life care.”³²⁴ Clergy members visiting would be required to follow safety protocols, enter voluntarily, and agree to substantial waiver of liability of the facility for harm resulting from the visit.³²⁵ As expansive as this seems, however, the statute indicates that it shall be preempted by federal statutes or “guidance” that is stricter.³²⁶ Furthermore, it authorizes the Department of Health to promulgate time, place, and manner restrictions on visits that may create some barriers to clergy access.³²⁷

Recognizing the importance of clergy visits, Arizona’s statutory amendment required that “if a hospital’s visitation policy allows in-person visitation of any kind . . . the hospital must facilitate the ability of clergy to visit the patient in person.”³²⁸ This would ensure that clergy could not be treated worse than other hospital visitors could. However, it did not establish any minimum visitation requirements, and it did not apply outside the hospital context to congregate residential settings.³²⁹

North Carolina adopted the Jeff Rieg Law.³³⁰ This was designed specifically to protect the right to clergy visitation during declared disasters and emergencies.³³¹ Unfortunately, however, the protections of the Jeff Rieg Law are extended only to hospital patients and not to residents of congregate residential settings.³³²

³²³ LA. STAT. § 40:2005.1(A).

³²⁴ *Id.* § 40:2005.1(B)(1).

³²⁵ *Id.* § 40:2005.1(A); *id.* § 771(B)(2)(c)(ii).

³²⁶ *Id.* § 40:2005.1(B)(3).

³²⁷ *Id.* § 40:2005.1(B)(1)–(2).

³²⁸ ARIZ. REV. STAT. § 36-407.01.

³²⁹ Nevertheless, the statute did appear to satisfy a need. *See, e.g., Arizona Bishops Praise New Hospital Clergy Visitation Law*, CATH. NEWS AGENCY (May 7, 2021, 6:00 PM), <https://www.catholicnewsagency.com/news/247581/arizona-bishops-praise-new-hospital-clergy-visitation-law>.

³³⁰ H.B. 447, Sess. Law 2021-156, 2021 Leg. Sess., Reg. Sess. (N.C. 2021); N.C. GEN. STAT. § 131E-84.05.

³³¹ N.C. GEN. STAT. § 131E-84.05. Clergy visits under this act would require that clergy members comply with screening and other safety protocols and that the visits be requested by or consented to by the resident. *Id.*

³³² *Id.*

5. Virtual Visitation Support

Other states included support for virtual visitation in their statutes in addition to, or in lieu of, more robust in-person visitation rules.

Illinois, for example, amended its Nursing Home Care Act to require that nursing homes establish robust capability for, and resources devoted to, facilitating virtual visitation through assistive and supportive technology and devices.³³³ Although the statute noted that “research. . . shows in-person interactions is the preferable and more impactful avenue for family, friends, and clergy to connect with and support nursing home residents,”³³⁴ it did not prohibit restrictions on in-person visitation in times of emergency.³³⁵ However, in the context of virtual visitation, the legislation repeatedly mentioned the importance of clergy visits and religious activity in a way more robust than many other statutes on this issue.³³⁶

Again, this is but a small sampling of the approaches some states have taken to address the problem. Unfortunately, there is a great deal of inconsistency with respect to these critical rights. Moreover, other states had proposals made but not passed—indicating that, perhaps, when the crisis passed, political support waned.

IV. A PROPOSAL FOR ENSURING ACCESS TO VISITATION AND SPIRITUAL CARE IN TIME OF CRISIS

The COVID-19 emergency exposed serious shortcomings in the way in which vulnerable persons are cared for in congregate residential settings. At the most obvious level, the high rates of death—and the ways in which COVID-19 was poorly managed in the pandemic’s early days—wreaked havoc on the physical health of vulnerable residents.

However, the long-term isolation from loved ones also created devastating consequences for residents and their families. Before considering any reform proposals, an honest inquiry into and assessment of these consequences is essential.³³⁷

³³³S.B. 2137, Pub. Act. No. 102-0640, 102d Gen. Assemb., Reg. Sess. (Ill. 2021). For commentary on the Illinois approach, see Cerminara et al., *supra* note 4, at 364.

³³⁴Ill. S.B. 2137.

³³⁵*Id.* sec. 10, § 5-45.8.

³³⁶*Id.* sec. 1.

³³⁷See Cerminara et al., *supra* note 4, at 362 (“Research on the mental health effects of low-visitation and no-visitation policies during COVID and its variants is crucial to striking the proper and necessary balance between public health and residents’ rights in the future.”).

As seen above, various jurisdictions have reacted to this in a variety of ways. However, a comprehensive approach is needed.

This proposal to ensure access to visitation and spiritual care in time of crisis has two prongs: (1) greater attention to pre-crisis planning; and (2) specific legislation granting a more secure right to visitation both (a) generally; and (b) for spiritual care.

A. *Pre-Crisis Planning to Protect Visitation Rights*

First, it is important to review the safety of congregate living settings to ensure that, to the extent possible, future pandemics do not have such a devastating impact.³³⁸ As one commentator observed, “U.S. nursing homes were unstable even before Covid-19 hit. They were like tinderboxes, ready to go up in flames with just a spark. The tragedy unfolding in nursing homes is the result of decades of neglect of long-term care policy.”³³⁹ A full discussion of nursing home reform is beyond the scope of this article. Yet, it is painfully clear that congregate residential settings were largely unprepared for a pandemic.

³³⁸See Mengying He et al., *Is There a Link Between Nursing Home Reported Quality and COVID-19 Cases? Evidence from California Skilled Nursing Facilities*, 21 J. AM. MED. DIRS. ASS’N 905 (2020) (reviewing correlations between COVID-19 deaths and the quality ratings of California nursing homes). “Nursing homes with 5-star quality ratings showed significantly less COVID-19 cases compared with nursing homes with 1 to 4 star ratings. Larger nursing homes with higher bed occupancy rates were positively associated with COVID-19 cases and deaths.” *Id.* at 907. “Nursing homes with a lower proportion of white residents were more likely to have COVID-19 cases.” *Id.* “Compared with [not for profit] and government-owned nursing homes, [for profit] nursing homes have relatively more COVID-19 cases and related deaths.” *Id.* “A more recent study also found that nursing homes associated with large- and medium-for-profit chains had lower family ratings in terms of care experience and satisfaction.” *Id.* While this was a small-scale study conducted relatively quickly after the pandemic began, it suggests a link between poor quality of nursing homes and the inability of those homes to control COVID-19 harm to residents.

³³⁹Rachel M. Werner et al., *Long-Term Care Policy After COVID-19—Solving the Nursing Home Crisis*, 383 NEW ENG. J. MED. 903, 903 (2020); see also Giovenco, *supra* note 19, at 138 (“[T]he emergency response would always be insufficient because the LTC industry was unprepared and ill-equipped to handle a pandemic.”); *id.* at 152 (“[T]he heavily reactive approach was never the best option to keep LTCs safe because most of the issues stemmed from the inherent risks of the industry, vulnerability of elders and the community-type care that they receive.”); GAO-22-105133, *supra* note 1, at 1 (“Prior to the COVID-19 pandemic, infections were a leading cause of death and hospitalization among nursing home residents, with estimates of up to 380,000 residents dying each year.”); and *id.* at 6 (“Nursing home residents can be particularly susceptible to infections because of their advanced age and higher risk of comorbidities.”).

1. Review of Health and Safety Compliance

Immediately, a thorough review of nursing homes and other congregate residential settings is necessary to determine whether and where basic infection control measures were lacking.³⁴⁰ Such settings have long been vulnerable to infections.³⁴¹ According to the White House's statement on February 28, 2022, "[t]he Government Accountability Office found that, from 2013 to 2017, 82% of all inspected nursing homes had an infection prevention and control deficiency."³⁴² Given this deep-seated problem, visitation restrictions were much easier mitigation measures to implement. Thus, they were quickly imposed. It is critically important to address these deficiencies so that in future emergencies, visitation restrictions are the absolute last resort and not among the first.

More frequent inspections are critical as part of this. The GAO reports that today, "[s]tate survey agencies are required by federal law to perform unannounced, on-site standard surveys of every nursing home receiving Medicare or Medicaid payment at least every 15 months, with a statewide average frequency of every 12 months."³⁴³ Increasing the frequency of such inspections—and ensuring that they take place at all congregate residential settings for vulnerable residents—could be an essential part of discovering dangerous gaps in infection control protocols.

General reform measures are essential as COVID-19 "exposed long-standing problems in the nursing home industry that stem from chronic

³⁴⁰ See Giovenco, *supra* note 19, at 141 (noting a "strong correlation exists between COVID-19 outbreaks and facilities that have a history of substandard care, citations for failures to follow applicable laws, and a lack of adequate procedures to control infections."); and *id.* at 144 ("[I]ndependent researchers across the country have found that the nursing homes with the most problems—and lowest ratings—before the pandemic fared the worst during the pandemic.").

³⁴¹ See Antonisse, *supra* note 3, at 1806. ("While the public health risks of institutions have always existed, few people paid attention to these risks prior to COVID-19 despite warnings from some researchers and advocates about the frequency and severity of infectious disease outbreaks in institutions."); and GAO-22-105133, *supra* note 1, at 1 ("[I]n the years prior to the pandemic, nursing homes had persistent and widespread challenges with [infection prevention and control].").

³⁴² *White House Fact Sheet*, *supra* note 17. For a discussion of state-level regulations on infection control in the context of assisted living communities, see Taylor Bucy et al., *Variability in State Regulations Pertaining to Infection Control and Pandemic Response in US Assisted Living Communities*, 21 J. AM. MED. DIRS. ASS'N. 701 (2020). See also U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-576R, *INFECTION CONTROL DEFICIENCIES WERE WIDESPREAD AND PERSISTENT IN NURSING HOMES PRIOR TO COVID-19 PANDEMIC* (2020) (providing statistical analysis of incidents, rates, and severity of nursing home infection control violations prior to the outbreak of COVID-19).

³⁴³ GAO-22-105133, *supra* note 1, at 8.

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understaffing and underspending on care for residents.”³⁴⁴ A global pandemic on the scale of COVID-19 is rare. However, homes in which many medically vulnerable people live in close quarters can easily become places where infectious diseases of other types can spread quickly, with devastating impact—albeit on a smaller and, therefore, often unnoticed scale.³⁴⁵

While often not subject to the CMS regulatory regime—and thus supervised by a varied patchwork of state and local regulations—assisted living facilities and group homes must also have a heightened level of health and safety review.³⁴⁶

Greater attention must be paid to ensuring an adequate, well-paid staff to do the critical work of caring for residents of congregate residential settings. The GAO reported that, based on interviews it conducted with nursing home associations, “staff are exhausted, face burn-out from emotional trauma, need to quarantine due to exposure to or illness from the virus, or stay home to take care of family members—all of which further strains staffing resources.”³⁴⁷ The required staffing level of various facilities must be reviewed and increased if necessary to ensure safety in future crises. If this means that understaffed facilities must be closed, that will be in the interest

³⁴⁴Nina A. Kohn, *COVID Awakened Americans to a Nursing Home Crisis. Now Comes the Hard Part.*, WASH. POST (Apr. 28, 2021, 6:00 AM), <https://www.washingtonpost.com/outlook/2021/04/28/nursing-homes-covid-pandemic-reform-staffing/> (criticizing lack of quality care in nursing homes that long predated the COVID-19 crisis); see also Rachel Baldauf, *Watchdog Groups Laud Proposals to Improve Nursing Home Care and Call for Other Changes*, WASH. POST (Mar. 9, 2021, 5:31 PM), <https://www.washingtonpost.com/business/2021/03/09/nursing-home-covid-deaths-pandemic/> (discussing proposals to reform and improve the quality of care in nursing facilities); English, *supra* note 20, at 15 (noting that there are “[p]roblems with infection control in nursing homes, a long-time issue that the pandemic has exacerbated”); Giovenco, *supra* note 19, at 127 (“The difficulty of controlling infections in LTCs coupled with the inherent vulnerability of elders created a crisis in that LTCs lacked disaster preparedness.”); and Khimm, *supra* note 20 (calling for “strict accounting of how nursing homes use the public money that fills their coffers”).

³⁴⁵The GAO has recently made three recommendations to the CMS Administrator to enhance infection protections at nursing homes. These recommendations are to: (1) “Establish minimum infection preventionist training standards”; (2) “Collect infection preventionist staffing data and use these data to determine whether the current infection preventionist staffing requirement is sufficient”; (3) “Provide additional guidance in the State Operations Manual on making scope and severity determinations for IPC [infection prevention and control]-related deficiencies.” GAO-22-105133, *supra* note 1, at 33.

³⁴⁶See Lexi Pitz, Note, *The Critical Need for State Regulation of Assisted Living Facilities: Defining “Critical Incidents,” Implementing Staff Training, and Requiring Disclosure of Facility Data*, 105 MINN. L. REV. 1009 (2020) (describing, with disturbing detail, the lack of oversight of health and safety in assisted living communities prior to COVID-19).

³⁴⁷GAO-21-402T, *supra* note 14, at 7. See also *id.* (“[N]ursing home staffing challenges were difficult and ongoing throughout the pandemic . . .”).

of public health.³⁴⁸ Salaries for those who do the arduous work of caring for vulnerable people must also be reassessed and increased whenever possible to reflect the importance of their labor. Inadequate pay meant that some staff worked in multiple facilities—a factor that contributed to infection spread.³⁴⁹ It also meant fewer trained personnel to implement infection precautions effectively.³⁵⁰

A concerted effort must be initiated to ensure that adequate supplies of high-quality, appropriate PPE are kept in reserve at congregate residential settings so that in the future it is readily available for essential employees, residents, and critical visitors.³⁵¹

Greater attention must be paid to ensuring that high-quality emergency response plans are carefully created, reviewed, and updated for every congregate residential setting. Measures to protect visitation rights should be a critical part of that. If something is a priority—as visitation must be—then it should be measured. Sadly, many proposals for nursing home reform, including those announced by the White House in February 2022, do not mention visitation rights.³⁵² Emergency plans that prioritize visitation should be a critical part of the accreditation regime for all congregate residential settings. These plans should be publicly available to residents, prospective residents, their families, and the concerned public. Before the next public health crisis, general safety guidance for visitors³⁵³ that establishes safety protocols short of visitation bans such as PPE, testing, distancing,

³⁴⁸ See *White House Fact Sheet*, *supra* note 17 (describing new CMS initiative to “establish a minimum nursing home staffing requirement” since “adequacy of a nursing home’s staffing is the measure most closely linked to the quality of care residents receive”).

³⁴⁹ See Khimm, *supra* note 20 (addressing dangers of spread by contact caregivers or staff employed in multiple facilities); and Abrams, *supra* note 20 (noting that poorly paid health care workers “often work for multiple facilities to make ends meet, potentially spreading infections further”).

³⁵⁰ See Khimm, *supra* note 20 (“[F]acilities with more aide hours per resident had fewer deaths and smaller outbreaks”); and *id.* (“[A] lack of staff makes it difficult to take precautions such as isolating residents”).

³⁵¹ See Williams, *supra* note 16, at 47–50 (chronicling shortages of PPE in congregate residential settings).

³⁵² See generally *White House Fact Sheet*, *supra* note 17 (neglecting to mention either visitation or spiritual care). See also Judith Graham, *To Families’ Dismay, Biden Nursing Home Reform Doesn’t View Them as Essential*, U.S. NEWS & WORLD REP. (Mar. 18, 2022, 5:00 AM), <https://www.usnews.com/news/health-news/articles/2022-03-18/to-families-dismay-biden-nursing-home-reform-doesnt-view-them-as-essential>.

³⁵³ See Frampton et al., *supra* note 59, at 2 (outlining components of facilitating family members’ presence during COVID-19 and other health emergencies).

registration, contact tracing,³⁵⁴ and training³⁵⁵ must be established. Together, all of this would make visitation policies far more flexible and rational.³⁵⁶ Addressing these needs will mean that responses to future infectious disease emergencies can impose isolation as a last resort rather than one of the first.

States should also resist proposals to shield nursing homes from liability.³⁵⁷ To the extent that harm occurred due to inadequate advance planning, liability shields may disincentivize better future planning. Rather, a new emphasis on robust inspections³⁵⁸ and significant penalties for violations³⁵⁹ is critically important.

The overall design of congregate residential settings must also be reviewed to prioritize safe visitation even in the event of future pandemics. Certainly, creating safe, climate-protected outdoor areas where residents can meet freely with visitors should be mandated when feasible. Rather than makeshift tents and space heaters, healthy, safe, and pleasant outdoor spaces should be a part of the basic residential design.³⁶⁰

Beyond that, the design of congregate residential settings should be reimaged to make them more conducive to safe operations in times of crisis.³⁶¹ The national aging demographic suggests an increased need for

³⁵⁴ Frameworks have been proposed in other contexts establishing best practices for facilitating and reducing the risk of visits during a time of COVID-19. *See generally* Bloomer & Bouchoucha, *supra* note 226, at 133 (proposing guidance for family visits for patients dying in the ICU).

³⁵⁵ For a discussion of what such training might entail, see COMMISSION FINAL REPORT, *supra* note 16, at 26–27.

³⁵⁶ A similar argument was made in Aimonetti & Talley, *supra* note 236, where the authors argued that claims of religious groups that pointed out the over-inclusive and under-inclusive nature of restrictions on religious gatherings helped to make those restrictions both more accommodating of religious practice but more scientifically rational as well.

³⁵⁷ A full discussion of this controversial proposal is beyond the scope of this article. Others have written about it at greater length. For a compelling argument against a liability shield, see generally Betsy J. Grey, *Against Immunizing Nursing Homes*, U. CHI. L. REV. ONLINE (June 18, 2021), <https://lawreviewblog.uchicago.edu/2021/06/18/grey-nursing-homes/>. The broader question of liability shields was also explored in Valerie Gutmann Koch, *Crisis Standards of Care and State Liability Shields*, 57 SAN DIEGO L. REV. 973 (2020). *See also* Shilling, *supra* note 42 (observing that “even nursing home residents who were not infected experienced fear, social isolation and loss of activities important to them, and were essentially cut off from family members”).

³⁵⁸ *See White House Fact Sheet, supra* note 17 (“President Biden will call on Congress to provide almost \$500 million to CMS, a nearly 25% increase, to support health and safety inspections at nursing homes.”).

³⁵⁹ *See id.* (“President Biden is . . . calling on Congress to raise the dollar limit on per-instance financial penalties levied on poor-performing facilities, from \$21,000 to \$1,000,000.”).

³⁶⁰ A thoughtful analysis of the ways in which nursing home designs must be reevaluated is presented in Diana C. Anderson et al., *Nursing Home Design and COVID-19: Balancing Infection Control, Quality of Life, and Resilience*, 21 J. AM. MED. DIRS. ASS’N 1519 (2020).

³⁶¹ *See* Charles P. Sabatino & Charlene Harrington, *Policy Change to Put the Home Back into Nursing Homes*, 42 BIFOCAL 119, 122 (2021).

congregate residential settings, making safe environments more critical and urgent.³⁶² Innovations such as greater emphasis on individual rooms,³⁶³ smaller communities rather than large scale facilities,³⁶⁴ improved ventilation,³⁶⁵ creation of multiple entrances, and the ability to separate or cohort residents should also be incorporated in the redesign of congregate residential settings. This will better safeguard residents in the time of the next major public health crisis.³⁶⁶

³⁶² See Halabi, *supra* note 19, at 584 (predicting that “[t]he number of Americans requiring a nursing home will double by 2030”).

³⁶³ See *White House Fact Sheet*, *supra* note 17 (acknowledging that “multi-occupancy rooms increase residents’ risk of contracting infectious diseases” and declaring that “CMS will explore ways to accelerate phasing out rooms with three or more residents and to promote single-occupancy rooms”).

³⁶⁴ See Hannah R. Abrams et al., *Characteristics of U.S. Nursing Homes with COVID-19 Cases*, 68 J. AM. GERIATRICS SOC’Y 1653, 1653, 1655 (2020) (addressing impact of facility population on COVID-19 outcomes and concluding that “[l]arger facility size, urban location, greater percentage of African American residents, non-chain status, and state were significantly . . . related to the increased probability of having a COVID-19 case” but also that “while smaller facilities are less likely to have outbreaks, outbreaks at small facilities affect more patients per bed”).

³⁶⁵ See generally Giovenco, *supra* note 19, at 151 (detailing ventilation reforms that could increase the health and safety of congregate residential settings); see Richard M. Lynch & Reginald Goring, *Practical Steps to Improve Air Flow in Long-Term Care Resident Rooms to Reduce COVID-19 Infection Risk*, 21 J. AM. MED. DIRS. ASS’N. 893 (2020) (proposing safeguards in ventilation systems).

³⁶⁶ See, e.g., Veronese & Barbagallo, *supra* note 20, at 3 (noting that even pre-COVID-19, “researchers proposed that actual nursing homes are not adapt for older people being, for example, too large, with poor privacy and not encouraging social interactions among residents”); Guidry-Grimes, *supra* note 18, at 29 (arguing in favor of “[s]ignificant investment in congregate care settings . . . to rethink their architectural design . . . , improve remote forms of communication and recreation, carry out advance planning in case of public health disasters, obtain resources that will diminish the hazards of catastrophic events”); Rebecca Tan, *Nontraditional Nursing Homes Have Almost No Coronavirus Cases. Why Aren’t They More Widespread?*, WASH. POST (Nov. 3, 2020, 6:00 AM), https://www.washingtonpost.com/local/green-house-nursing-homes-covid/2020/11/02/4e723b82-d114-11ea-8c55-61e7fa5e82ab_story.html (describing the benefits of the small scale “Green House” model of elder care “which allows the elderly to live in groups of eight to 10 in settings that resemble homes rather than hospitals,” and praising the low level of COVID-19 infections and deaths in such facilities vis-à-vis traditional nursing homes); and English, *supra* note 20, at 15–16 (critiquing “[n]ursing home designs that make it easy for infections to spread,” and advocating the benefits of “Green House” design for nursing homes). Dr. Werner expresses a similar sentiment:

Better options can help ensure that the tragedy currently unfolding in nursing homes never happens again. Smaller-scale, high-quality group models, such as the Green House Project, provide care in small, self-contained, family-style houses with a small number of residents. Such models could offer one community-based alternative to nursing homes. . . . Though building out these models requires substantial investment, we are now seeing for ourselves how critical that investment is.

COVID-19 has, indeed, “created a once-in-a-generation opportunity for far-reaching changes targeting the issues that left these facilities so vulnerable in the first place.”³⁶⁷ To squander this would miss the chance to draw good from the tragedy of COVID-19.

2. Alternatives to Congregate Residential Settings

In light of COVID-19’s disproportionate impact on those in congregate residential settings, broader discussions about ways to strengthen and expand home and community-based services for vulnerable people are accelerating. This would mean that fewer people live in congregate residential settings. Indeed, “infection and death rates among people with disabilities and older adults could have been far more limited if this population had broader access to home and community-based services.”³⁶⁸

Doing this in an aggressive, thoughtful way would not only honor the widespread preferences of many individuals and families. It would also offer an alternative to a congregate residential setting entirely. This may help reduce transmission of disease and reduce the likelihood of forced isolation. This is a far broader discussion than this article allows.³⁶⁹ However, planning for the next health crisis—by both enhancing the safety of congregate residential settings and increasing home-based alternatives—will reduce the number of vulnerable people deprived of visitation.

B. Legal Protection of the Right to Visitation in Time of Crisis

Regardless of the quality of advanced planning, future health crises may still come. When they do, preserving residents’ access to visitation must be a priority. This must be done proactively and legislatively so that the right to

Werner et al., *supra* note 339, at 904. A more extensive discussion of the ways in which the physical conditions of nursing homes might be better designed to prevent infection and increase residents’ quality of life may be found in COMMISSION FINAL REPORT, *supra* note 16, at 56–59.

³⁶⁷ Khimm, *supra* note 20; see also Karen Wolk Feinstein, *What COVID-19 Exposed in Long-Term Care*, HEALTH AFFS. FOREFRONT (Nov. 5, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20201104.718974> (stating that, with respect to congregate residential settings post-COVID-19, “recommendations will have to be disruptive, challenge the status quo, and boldly request the necessary funding and medical resources”); and Lynch & Goring, *supra* note 365 (proposing safeguards in ventilation systems).

³⁶⁸ Antonisse, *supra* note 3, at 1804.

³⁶⁹ This issue, and options and challenges for implementing them, is beyond the scope of this article but thoughtfully and fully explored in Elizabeth Edwards et al., *Retaining Medicaid COVID-19 Changes to Support Community Living*, 14 ST. LOUIS U. J. HEALTH & POL’Y. 391 (2021). See also Antonisse, *supra* note 3, at 1809–10.

visitation is not easily suspended. This protection of the right to visitation must include *both* the right to general visitation of loved ones *and*, more specifically, the right to spiritual care.

1. General Visitation

As a general matter, the pre-COVID-19 CMS regulations regarding the importance of visitation should be the starting point. Furthermore, congregate residential settings other than nursing homes should have similar statutory articulation of the right to visitation of family members, friends, service providers, and providers of spiritual support. This should be the accepted norm, and one that should only be suspended in the most critical of emergencies—emergencies that should not be declared unless necessary and that should not be expanded any longer than strictly necessary. The threshold “norm” should be one in which those in congregate residential settings have unlimited access to visits from their loved ones, subject only to residents’ consent and the expectation that the visitors will respect reasonable behavioral rules while visiting.

However, once an emergency such as the one that existed during COVID-19 is declared, there are still important rights to visitation that should be retained. This should be in the form of both federal legislation and state legislation.

Federal action is needed because it is CMS that regulates nursing homes, and many veteran’s hospitals and other congregate residential settings are subject to federal control. States cannot allow nursing homes within their borders to violate CMS regulations. Hence, a federal statute establishing threshold rights is necessary. Because of the significant role that the federal government plays in funding nursing homes and in setting influential policies, the federal government should take the lead and offer meaningful

assistance to state and local governments.³⁷⁰ This should begin with a clear declaration that “[r]estate[s] the existing right to visitation.”³⁷¹

However, state law is critically important as well. There are many facilities, such as assisted living settings and certain group homes, that are primarily regulated by state law. Hence, such local guidance is essential.

With respect to general visitation, if all the broader reforms outlined above are taken seriously and funded appropriately, the expectation should be that visitation will continue as usual. If it cannot be, two rights should be clearly established on both the state and federal levels.

First, there is a difference that seems to have gone unappreciated “between casual visitation and the essential role that family care partners play as members of the care team.”³⁷² If a time arises when an emergency makes it necessary to suspend general visitation and curb “casual” visitors, residents should be allowed to designate at least *two* “essential care partners” who will be allowed to visit as long as they abide by the same safety protocols as the staff of the residential settings.³⁷³ The resident (or his or her legal guardian) should designate whom these “essential care partners” will be, and their right to visitation should not be suspended. An alternate (or several alternates) should also be designated in case illness or other emergency prevents visitation from the “essential care partners” originally designated to visit.

Unlike some state enactments, these “essential care partners” should not be required to provide any physical care, nor should there need to be a finding that the resident requires assistance. Rather, the “essential care partners”

³⁷⁰ See Halabi, *supra* note 19, at 616–17 (explaining the division of regulatory authority over nursing homes between state and federal governments and arguing that comprehensive federal regulation and enforcement is necessary to ensure the safety of nursing homes). Professor Halabi argues that there must be “explicit acknowledgement that the elderly population in nursing homes is a federal responsibility and that the federal government should lead the certification of nursing homes, protect them from spatial marginalization, and allow residents and families to enforce those measures.” *Id.* at 616. He goes on to argue that “[i]t is time to acknowledge federal primacy over nursing homes, and amend the state-level bureaucracies that explain much of the dysfunction that led to severe COVID-19 mortality.” *Id.* at 617. The complexity of federal and state roles in nursing home regulation is further explored in Shilling, *supra* note 42 (“[A]lthough much of the funding for care of the elderly comes from federal programs . . . and there are detailed (albeit ambulatory) federal regulations, the states have a major role in health care regulation.”).

³⁷¹ COMMISSION FINAL REPORT, *supra* note 16, at 33.

³⁷² Frampton et al., *supra* note 59, at 2.

³⁷³ Others have proposed only one essential visitor. See Cerminara et al., *supra* note 4, at 364. This has appeal from an infection control perspective, and it is certainly better than the visitation rights afforded during the COVID-19 pandemic. However, allowing only a single visitor may not fully appreciate the critically different role that each “essential” caregiver provides. A long-term spouse may provide comfort and assistance with personal care, while an adult child may be a more effective advocate.

should be the person(s) that the resident most wishes to visit. This respects the view that, far from being a luxury, companionship is essential care. Ideally, the essential care partners will assist their loved ones with direct physical care, such as assistance with grooming or mealtime. However, as COVID-19 has taught, mere presence is itself a form of critical care.

Concededly, visits from “essential care partners” could increase infection risk. Thus, essential care partners must follow employee protocols for such things as PPE, testing, safety training, distancing, etc., to help mitigate this. The cost of such things as PPE and testing should be borne by the residential facility and not the resident or essential care partner. In this manner, and with advanced planning, the facilities can obtain high-quality and effective supplies with the specialized knowledge that they have.

An individual resident (or his or her legal guardian) may choose to forego visits from the essential care partners if they assess their personal risk warrants this choice. The resident and the “essential care partners” should be provided with full, accurate disclosures of the risks of their visits. They should be offered information about alternatives such as virtual visits and outdoor visitation should those be acceptable options. Visitors and residents should acknowledge acceptance of these risks in writing and agree to hold the congregate residential setting’s management harmless except in cases of gross negligence in managing the visitation.

If the emergency is dire, some time, place, and manner restrictions may be placed on the access of “essential care partners.” These could include requiring that only one be present at the same time, limitation on hours, and advanced notice of visits. However, each resident should be allowed at least one “essential care partner” visitor for a minimum of four hours each day to ensure steady, reliable companionship.

Second, in addition to the limited number of “essential care partner” visits, those in clearly defined “compassionate care situations” should be allowed to have more expansive visitation. For those in end-of-life situations, “compassionate care visitation” should be allowed without any restrictions other than those that are the standard normal time, place, and manner restrictions that would apply in non-emergency situations.

For other discrete “compassionate care” situations short of “end-of-life” situations, including:

- Residents in the first three months in a new home;
- Residents in bereavement after the death of a loved one;
- Residents experiencing rapid weight loss or dehydration due to failure to eat or drink;

- Residents exhibiting signs of depression, acute agitation, or clinical “failure to thrive”; and
- Residents receiving a new medical diagnosis or making significant medical decisions;

residents should be able to designate an additional two “essential care partners” to visit them. These additional “essential care partners” need not be designated in advance as the original two are because the particular situation might determine whom the resident might select.

The benefit of this approach is that—except for end-of-life—the visitors who will be allowed will all be “essential care partners.” The original two are the ones expected to play the primary role in helping the resident maintain physical, mental, and emotional health. Then, in one of the five discrete situations outlined above—situations frequently identified as constituting “compassionate care situations”—two additional “essential care partners” can be designated. The fact that they are designated in advance means that the facility will be able to contact them, offer information and guidance, and communicate risks. This avoids creating a completely open visitation model. Yet, it also gives the resident (or his or her guardian) the ability to adjust who should be an “essential care partner” depending on the nature of the compassionate care situation that arises.

2. Spiritual Care

The provision of spiritual care—which would encompass clergy visits—is a second right to visitation that must be protected for those in congregate residential settings.

In recognition of the importance of spiritual care, it should be designated as “essential care.” In other contexts, “legislatures can preemptively define certain activities as ‘essential’ or ‘life-sustaining.’ As a result, state governors would not be able to shutter, on an ad hoc basis, certain activities deemed as non-essential.”³⁷⁴ The act of spiritual care and religious exercise itself must be recognized as “essential.” Once this is done, clergy members should—upon request of a resident—be able to visit residents on the same basis as anyone else providing essential services to that resident. This would not require a resident to designate a member of the clergy as an “essential care partner” because the designation of clergy members as “essential” will be presumed for all.

³⁷⁴Blackman, *supra* note 12, at 756.

To maintain order in visitation during emergencies, except in end-of-life situations or circumstances in which a sincerely held religious belief demands visitation at a particular time, there can be reasonable time, place, and manner restrictions on clergy visits. There are likely to be such restrictions on others providing essential services to residents. In addition, while drawing distinctions in matters as personal as religion is difficult, this right of visitation should be addressed to clergy members, however clergy is formally defined for analogous purposes. This may exclude lay volunteers and others who may offer meaningful spiritual support. However, to the extent that visits from non-clergy are desired, they should be designated as one of the “essential care partners.”

The clergy who visit have a responsibility, along with governments, health care facilities, patients, and residents, to be mindful of the risks and reduce them in all reasonable ways.³⁷⁵ To ensure that spiritual care is provided in congregate residential settings, faith communities and clergy members have obligations and should play a leadership role developing

³⁷⁵ See Hall, *supra* note 217, at 2285 (“Clergy must be held accountable for safe practices, and most will do so responsibly. . . . But ignoring the pastoral needs of patients is not an option.”). Brady commented on the analogous context of public, community worship services:

[R]eligious leaders and government officials both have a role to play in developing the restrictions that apply to worship. Government officials must communicate with religious leaders and give them an opportunity to provide input as decisions are made and rules are reevaluated and adjusted. . . . Government officials and religious leaders must be partners in addressing the risks of COVID-19 because both have critical interests at stake. Effective partnerships also build trust and reduce the likelihood that religious congregations will violate safety rules or insist on risky behaviors. . . . Religious believers are weary of the restrictions associated with COVID-19 as are all Americans. However, if religious adherents believe that their governments recognize the urgency of their concerns and will work with them to mitigate the effects of the virus on their faith lives, all of our communities will be safer and more stable.

Brady, *supra* note 192. Dr. Jean Abbott makes clear why we must be careful of risks associated with visitation:

Hospitals, nursing homes, and other facilities must reduce the risk of patients dying alone in isolation by loosening overly restrictive visitation policies for dying patients, providing adequate personal protective equipment for their visitors, and ensuring tools for virtual visitation. Hospitals are not prisons, and patients and families should be allowed to undertake reasonable risks of visitation with dying loved ones, with the understanding that this exposure could result in potential illness among visitors or may entail subsequent quarantine.

Jean Abbott et al., *Ensuring Adequate Palliative and Hospice Care During Covid-19 Surges*, 324 J. AM. MED. ASS’N 1393, 1394 (2020) (footnote omitted).

policies relevant to providing spiritual care.³⁷⁶ Faith communities might consider whether they have resources to support a cadre of healthy, specially trained chaplains to take a leading role in providing care in congregate residential settings during times of crisis.³⁷⁷ Faith communities should take seriously their legal and moral obligations to render spiritual care in ways that safeguard those they visit, themselves, and the community. This would include things as fundamental as wearing PPE as warranted,³⁷⁸ undergoing health and safety training,³⁷⁹ and quarantining, if necessary, either prior to or after conducting visitations. It should include informed acceptance of the risks that may come with a willingness to sign disclosures of known risks and an understanding that faith communities and individuals who fail to comply with health and safety protocols may lose their visitation rights. Individualized risk assessment should fine-tune the way clergy members and others providing spiritual care will have access to specific facilities in times of crisis.³⁸⁰

³⁷⁶ See, e.g., Zeh et al., *supra* note 29, at 774 (suggesting potential “[a]lternatives to strict ‘no-visitor’ policies, such as permitting limited visitors, allocation of personal protective equipment, or expanded COVID testing”).

³⁷⁷ See Janice Neumann, *As the Pandemic Got Underway, a Team of Priests Formed to Go into Hospitals to Anoint the Sick, Give Last Rites: ‘It Brought Them Such Consolation’*, DAILY SOUTHTOWN (Apr. 24, 2021, 5:00 AM), <https://www.chicagotribune.com/suburbs/daily-southtown/ct-sta-pandemic-priests-st-0425-20210424-gkxe6woxrjcpbil3wudyycmh2m-story.html> (describing volunteer group of forty-five priests from the Archdiocese of Chicago who volunteered to anoint the sick during the pandemic); see also Javonte Anderson, *Cadre of Chicago-Area Priests Trained to Minister to Dying Coronavirus Patients*, CHI. TRIB. (Apr. 6, 2020, 2:54 PM), <https://www.chicagotribune.com/coronavirus/ct-coronavirus-chicago-last-rites-priests-squad-20200406-ht5xzf3umna6vi5vfy5rntcz2a-story.html>. But see Simon Caldwell, *English Bishops Advising Priests Not to Give Last Rites*, CATH. REG. (Apr. 9, 2020), <https://www.catholicregister.org/home/international/item/31425-english-bishops-advising-priests-not-to-give-last-rites>.

³⁷⁸ See Bloomer & Bouchoucha, *supra* note 226, at 133 (stressing the importance of making PPE available to and requiring it of visitors).

³⁷⁹ Neumann describes the type of training offered to priests who volunteered to anoint the sick in hospitals:

[T]he training covered every part of the ministry, from the time the priests were contacted and asked to anoint a patient through their return to their parishes. The priests were also given personal protective gear and supplies for their visits. They received further instruction from nurses on site. . . . [T]he priests participated in more than 1,400 calls to anoint, and only one priest was infected. He fully recovered.

Neumann, *supra* note 377.

³⁸⁰ Amnesty International asserted the importance of this with respect to all visitors:

Achieving the right balance between allowing care homes residents meaningful contact with their families and managing the risk of infection is undoubtedly challenging. To be

As is true of “essential care partners,” clergy should be provided with full disclosures of the risks of their visits. They should be offered information about alternatives such as virtual visits and outdoor visitation should those be acceptable options. Clergy and the residents they visit should acknowledge acceptance of these risks in writing and agree to hold the congregate residential setting’s management harmless except in cases of gross negligence in managing the visitation.

Faith communities must also be open to innovation³⁸¹ and “forge innovative and clear pathways for chaplains to provide reliable spiritual care services throughout the pandemic and beyond.”³⁸² They should also be proactive in developing guidance to ensure that their clergy who can will be able to serve the faithful in safety.³⁸³ Yet, they should resist efforts to impose particular forms of spiritual care—such as online worship—when they may not be appropriate.

CONCLUSIONS

Although there is a compelling interest in physical health, “personal and public health are not the only human values worth pursuing—even in a

sure, the balance may need to be periodically adjusted depending on the level of transmission in the community and the situation of individual residents and of the specific care home. A zero-risk solution does not exist Care home residents should not be subject to blanket restrictions on their private and family life, except for restrictions which are appropriate to their specific circumstances based on individualised risk assessments.

AMNESTY INT’L, *supra* note 187, at 41; *see also* Gostin et al., *supra* note 9, at 11 (noting “we are witnessing large-scale quarantines imposed without any individualized risk assessment” in circumstances where “many nursing homes have gone on ‘lockdown’ mode, forbidding residents to leave or visitors to enter the facility,” and arguing that “these orders must follow rigorous safeguards, including opting for the least restrictive alternative, depending on scientific assessment of risk and effectiveness, ensuring procedural due process, and providing a safe and habitable environment”).

³⁸¹ *See, e.g.*, Joshua R. Edgar & John W. Ehman, *Telechaplancy: Preserving the Character of Chaplaincy Care in Telephone Interaction*, PENN MED. (May 6, 2021), <http://www.uphs.upenn.edu/pastoral/Telechaplancy.pdf>.

³⁸² Ferrell et al., *supra* note 26, at e10.

³⁸³ Some resources have been recently developed during COVID-19. *See, e.g.*, *Pastoral Care in a Time of Coronavirus*, EPISCOPAL DIOCESE N.C., <https://www.episdionc.org/coronavirus-pastoral-care/> (last visited. Nov. 12, 2022); COVID-19 ASSEMBLY OF BISHOPS TASK FORCE, *COVID-19 PANDEMIC: GUIDELINES & CONSIDERATIONS FOR PASTORAL HOME VISITATIONS* (2020), <https://www.assemblyofbishops.org/assets/files/covid19/Pastoral%20Visitations%20Guidelines%20%26%20Considerations.pdf>.

pandemic.”³⁸⁴ Those who live in congregate residential settings have borne the brunt of the COVID-19 pandemic in a literal, physical way. However, they have also suffered more than others have from the isolation imposed by visitation restrictions and, in a particular way, from the lack of access to loved ones and to spiritual care. As the response to COVID-19 is assessed in the years to come, greater planning must focus on ensuring that the most vulnerable among us are better protected from the ravages of disease. However, they must also be protected from the devastating consequences of isolation. This is often not noticed—because the isolated suffer in silence.

³⁸⁴Hall, *supra* note 217, at 2284. Hall goes on to note that “[n]ot everything that matters can be measured, and not everything measured matters.” *Id.* at 2286. In a similar vein, see Jules Storr et al., *supra* note 44 (“Failing to show humanity in how we treat our most vulnerable undermines trust.”); COMMISSION FINAL REPORT, *supra* note 16, at 28 (noting that members of the public who responded to requests for input “noted the importance of social and emotional health, along with the need for evidence-based policies regarding cohorting, nursing home design, and visitation. . . . significant work remains to be done to balance the costs and benefits of restrictive policies against the consequences of minimal care and decreased socialization.”); Paananen et al., *supra* note 186, at 9 (“[G]ood intentions may easily have poor consequences. . . . [R]estrictions designed to protect health cause anxiety, heartbreak, fear, and other negative outcomes among nursing home residents and their [family members].”); and Charles C. Camosy, *We Need to Respect the Choice Not to Die of COVID-19 Alone*, RELIGION NEWS SERV. (Apr. 13, 2020), <https://religionnews.com/2020/04/13/we-need-to-respect-the-choice-not-to-die-alone-of-covid-19/> (“[T]here are values that trump the singular goal of lowering COVID-19 infection rates. One of those is the compassion to accompany loved ones as they pass away and provide them with clergy.”).