



City and County of San Francisco

Shelter Monitoring Committee

MEMORANDUM

TO: Shelter Monitoring Committee
FROM: Committee Staff
DATE: April 30, 2026
RE: February 2026 Staff SOC Report

Client Complaints

Five formal complaints were submitted through the SMC to City shelters in February 2026.

****Note: SMC receives Standard of Care complaints each month that do not end up being submitted in writing, either because they were resolved informally or the client did not provide basic necessary details. Narratives provide an overview of the types of complaints forwarded to each site. Not all sites have had a chance to respond to the complaints. Complaints may have already been investigated to the satisfaction of the site or its contracting agency; however, the Committee must allow each complainant to review the response, and the complainant determines whether s/he is satisfied. If the complainant is not satisfied, the Committee will investigate the allegations listed in the complaint.*

Bayview Nav (80)

Submitted to SMC: 2/9/26 Sent to shelter: 2/9/26 SMC received response: 2/18/26
Standards of Care (SOC) Allegedly Violated: 1, 2

Allegation 1 (SOCs 1, 2)

- According to the complainant, upon entering the shelter he was instructed to empty the contents of his bag onto the table and place the bag on the table. There was limited space, resulting in the bag falling to the ground. Staff shouted at him to pick it up. The complainant asked them not to talk to him like that. The staff member then entered his personal space and shoved him toward the door, causing him to fall and hit his head on the door. He was then informed he was being exited and would have a hearing.
- *The shelter responded that (per posted safety instructions) every guest is searched along with their belongings when they enter the site. The client behaved as if intoxicated, yelling and acting unreasonably aggressively. During the process, his backpack fell onto the ground which heightened his apparent aggravation. The care monitor “removed [the client’s] belongings in an attempt to create space between them and the process.” This further aggravated the client, which prompted the Assistant Shift Manager to intervene. Subsequently, the client pushed the table into the knee of the care monitor (which was later found to have “caused a contusion”). This action along with the guest’s aggressive behavior triggered an instinctive response from the care monitor who pushed the client backward (causing him to fall to the ground). Due to the complainant’s behavior he received an immediate DOS. In interviewing the care monitor, it was learned that he had a previous injury to the knee that made it sensitive.*

Division Circle Navigation Center (81)

Submitted to SMC: 2/11/26 Sent to shelter: 2/20/26 SMC received response: 2/27/26
Standards of Care (SOC) Allegedly Violated: 1, 8

Allegation 1 (SOCs 1, 8)

- According to the complaint, she had multiple ADA-related needs but was unaware that documentation from a medical provider was required to approve accommodations. As a result, services were denied until her case manager later explained the process. She stated that although a letter regarding her service dog was already on file, staff questioned the legitimacy of the dog's seizure-related tasks and challenged the need for the dog to be untethered while actively tasking. She further reported that one staff member yelled at her due to a personal fear of dogs.

The complainant also reported that a counseling supervisor made inappropriate and offensive remarks about her clothing on multiple occasions within the same week, despite being aware she had recently experienced sexual assault. She claims he repeatedly referenced her clothing in connection with the assault, implying that what she wore could encourage a perpetrator. She perceived these remarks as discriminatory, demeaning, and retraumatizing. Additionally, she reported that staff criticized her for vomiting, even though they know she has a health conditions and lacks access to a medically necessary diet. She further stated that when she attempted to raise concerns, she was told that complaints would only be addressed if multiple individuals reported the same issue. She reported feeling discouraged from pursuing further complaints.

- *Division Circle Navigation Center's policy is that all dogs are to remain leashed while they are on-site. The complainant did obtain a letter from their medical provider, stating the need for her dog to be off leash and they were able to accommodate this request. The Case Management Supervisor met with complainant to discuss medical appointments and applying for benefits for family members, as well as work with complainant on housing opportunities through another Community Benefit Organization. He supported the complainant in the most professional way possible while she was staying at the site. She was provided two daily meals by Meals on Wheels. These would have supported complainant's medically necessary diet. Staff support all guests that may be experiencing medical issues by contacting appropriate medical personnel or having them meet with the on-site medical provider to discuss any health conditions in further detail.*

A Woman's Place (82)

Submitted to SMC: 2/20/26 Sent to shelter: 2/20/26 Response: 3/6/26
Standards of Care (SOC) Allegedly Violated: 1

Allegation 1 (SOC 1)

- The complainant reports she has experienced harassment related to her religious beliefs. She identified another client as engaging in preaching and religious conduct directed toward her. She states that after staff and other clients became aware that she is "Pagan," this client began attempting to engage her in conversations about Christianity and reciting passages from the Bible during meals, which the complainant reports disrupted her ability to dine comfortably. The complainant further reports that a board in the dining area designated for announcements recently displayed large drawings of crosses and the phrase, "Jesus loves you." The complainant does not know who wrote these messages but reports that their presence contributed to her discomfort. The complainant states that she has repeatedly reported the other client's behavior to staff and requested support. She reports that staff did not intervene or otherwise address her concerns. She further alleges that during breakfast on 2/19/2026, the client engaged in preaching in the dining area and that staff present did not take

action to stop the behavior. Staff asked her what was wrong, then walked away snickering. The complainant believes that staff failure to intervene allowed the conduct to continue and contributed to an environment in which she felt unsupported. She also expressed her belief that staff may have been less responsive to her concerns due to shared Christian beliefs.

- *Staff and guests present observed the two clients making remarks about each other and intervened. The complainant felt staff should have done more. Ultimately, though, the shelter does not see how they can ask a guest not to speak about their religion. Staff have been coached to provide intervention if an interaction is escalating between two guests during mealtimes. The Site Director agreed with the complainant that if the other guest wrote "Jesus Loves You" on the whiteboard it would have been inappropriate. Guests are not allowed to utilize the whiteboard without permission.*

Next Door (83)

Submitted to SMC: 2/23/26 Sent to shelter: 2/23/26 SMC received response: 3/2/26
Standards of Care (SOCs) Allegedly Violated: 1

Allegation 1 (SOCs 1)

- The client-guest says "the head intake staff member" was dismissive and spoke in a demeaning manner throughout the intake process, making the guest feel unwelcome and disrespected due to homeless status. There was a repeated emphasis on the possibility of being "kicked out." The staffer otherwise failed to provide a proper orientation and created a "hostile intake experience."
- *The shelter stated that the staff member involved provided a statement regarding an intake for a female guest matching the circumstances described. According to him, the guest indicated she intended to use the shelter only for "signing in" while continuing to reside at a friend or boyfriend's residence. He had to let her know that shelter participation and the retention of a bed require active engagement with Care Coordinators and actual utilization of the assigned bed. He maintains that while he was firm in communicating these program expectations and the necessity of following HSH and shelter rules, he was not rude or dismissive. The "emphasis" noted by the complainant appears to have been a clarification of policy regarding bed loss (being "kicked out" of the system/program) if the bed is not utilized as required. Management stated that while staff may not be perfect and mistakes can occur, they believe he has learned from this experience. Moving forward, they committed to using this as an opportunity for further training on trauma-informed communication. Even when firm boundaries or policies must be set, they are expected to be delivered in a way that minimizes the potential for the client to feel disrespected or unwelcome*

Lower Polk TAY Navigation Center (84)

Submitted to SMC: 2/23/26 Sent to shelter: 2/23/26 SMC received response: 3/9/26
Standards of Care (SOC) Allegedly Violated: 1

Allegation 1 (SOCs 1)

- Per the client, he has filed internal grievances with the site but has received no response. He reports multiple concerns regarding the behavior of other guests, which staff have made minimal effort to address. The complainant states that one guest frequently masturbates in common areas in view of others. On one occasion, a staff member reportedly told the individual to stop and made a joking remark that "if he did not stop beating off, he was going to beat him." The complainant also reports that he awoke one night to find another resident rummaging through his belongings and discovered that some of his property had already been taken. Staff assisted in retrieving the items; however, when he asked how the matter would be addressed, he was informed that no further action would be

taken because staff were already “aware that the resident had previously stolen from others and had this habit.” He further alleges that staff members frequently sleep during the night shift, requiring guests to wake them when assistance is needed. Additionally, he reports that a female resident with mental health concerns often screams throughout the night and during various hours of the day. According to the complainant, staff respond by shouting back at her or shining flashlights rapidly, similar to a strobe effect, rather than attempting to de-escalate the situation. He states that this disrupts other residents’ ability to sleep and that no meaningful effort is made to address the behavior or provide support. The complainant also reports concerns regarding meal access. Although signage indicates that meals are available 24 hours per day, he states that there are no set mealtimes, that are adhered to. When he has requested food, staff have reportedly told him that the kitchen is closed and that they are short-staffed, despite his observation that multiple staff members were present in the office watching sports at the time. Finally, the complainant reports overhearing staff speak negatively about residents who “snitch” on them, which he believes contributes to an unhealthy and retaliatory environment.

- *An internal review was conducted by the shelter to assess the allegations. The investigation included interviews with staff, review of internal grievance records, and observation of daily operations and meal services. The shelter does provide meals on a 24-hour basis. The kitchen is only closed between 4:00 – 6:00 AM for cleaning. During this time, staff bring food to the 3rd floor for clients. Food and snacks are always available when requested. If a requested item is not immediately available, clients can submit a request, and a “food carer” provides the requested meal or snack. Ample food and snack supply is on hand at all times.*

Regarding the allegation of inappropriate behavior in the dorm area, this concern was brought to the attention of the site manager. She spoke with staff and all clients surrounding the bed area, who denied any such behavior. Staff conducted a walkthrough of the dorm and did not observe any inappropriate conduct. To further prevent potential incidents, however, she increased scheduled staff walkthroughs. The complainant has not mentioned to staff any issues regarding missing items. The shelter has a waiver in place stating that we are not responsible for lost or stolen items. Clients are provided with a locker and storage space to secure personal belongings. At intake, clients are advised not to leave property out in common areas to prevent loss or theft. Staff respond to residents’ behaviors, including theft and disruptive conduct, according to shelter policies. Items reported missing are retrieved when possible, and staff maintain oversight to ensure resident safety. Staff are present throughout shifts and respond to client needs, including nighttime assistance.

Efforts are made to de-escalate situations involving residents with mental health concerns while minimizing disruption for other residents. While the complainant reported several concerns, the investigation confirmed that meals and snacks are consistently available 24 hours per day, and procedures for resident safety and compliance with SOC’s are being followed. Staff provide accommodations for specific requests and maintain oversight during kitchen closures. The alleged inappropriate behavior in the dorm was not observed. However, LPTAY Navigation Center will: Remind all staff of the importance of immediate and respectful responses to client grievances; reiterate proper procedures for handling disruptive resident behavior, including de-escalation techniques and safeguarding personal property; ensure that all residents are aware of the procedure for requesting specific meals or snacks if unavailable, and that requests are fulfilled promptly; continue increased walkthroughs in dorms to prevent inappropriate conduct; and reinforce expectations for staff presence and engagement during all shifts, including nighttime. The LoPo TAY Navigation Center remains committed to full compliance with all Standards of Care and to maintaining a safe, respectful environment for all residents.

Staff Update and Committee Membership

Membership (Admin. Code Sec. 30.305)

There are currently **two unfilled seats** on the Shelter Monitoring Committee:

Seat 4 - shall be held by persons with experience providing direct services to homeless people through a community setting.

Seat 12 - shall be held by an employee of the Department of Public Health.

If you or anyone you would be willing to recommend is interested in applying for a Seat on the Committee, please contact staff at 628-652-8080 or email shelter.monitoring@sfgov.org for more information. the Homelessness Oversight Commission has a nominations subcommittee charged with recommending appointments to the SMC (and some other related groups). Applicants submit a [form](#) and the candidate(s) name is added to the Nomination Committee meeting agenda and invited to meet the members who conduct a soft interview. At this point, the candidate is also able to ask committee members questions. The full HOC will vote to approve the candidacy

Total Client Complaints FY 2025-2026*

Site	Site Capacity	7/25	8/25	9/25	10/25	11/25	12/25	1/26	2/26	3/26	4/26	5/26	6/26	Total FY25-26 Red indicates late response	Complaints per 100
Adante	70 Rooms			1			1							1	
711 Post/Ansonia	250 beds													4	
Baldwin	179 beds	1	1	2										2	
Bayshore Nav	128 beds	2												2	
Bayview Nav	203 beds			1					1					2	
Gough Cabins	70 rooms														
Central Waterfront Nav	60 beds														
Compass Family UAV	130 beds	2												2	
Dolores Street	92 beds			1		1	2							2	
Division Circle Nav	186 beds		1		2	1	1		1					6	1
Ellis Semi-Congregate	130 beds			1		2/2								3	2
Embarcadero Nav Cntr	200 beds	1				1								2	
Gough Cabins	70 rooms		1											1	
Hamilton	27 fams	1												1	
Harbor House Family	30 fams														
Hospitality House							1								
Interfaith Winter Shelter	30-80 bed														
Lark Inn	36 beds														
MSC South Shelter	327 beds		2/2	2/1	1		2							5 ¹	3
Lower Polk TAY	75 beds				1				1					2	
Mission Cabins	68 beds		1	closed										1	
Monarch	93 beds										Closed				
Next Door	334 beds		2			2	1		1					6	
Oasis Family	54 beds			1	1									2	
Sanctuary (ECS)	200 beds		1	2	4									7 ¹	
Taimon Booten	75 beds	2				1								3	
AWP Drop In	30 beds			2/1										2	1
A Woman's Place	25 beds								1						
Total		9	11	13	9	8	8		5					53	7

*Late responses are in red ¹ Multiple complaints from the same client(s)

Standard of Care	Number of allegations of violations of this Standard
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Note that each complaint can include alleged violations of more than one SOC or multiple violations of the same SOC.

SOC ↓	SOC Description	7/25	8/25	9/25	10/25	11/25	12/25	1/26	2/26	3/26	4/26	5/26	6/26	Total FY25-26	Complaints per 100
1 a	Rudeness	11	15	8	3	4			1						
b	Disrespect for property			4	2	4			1						
c	Bad/Retaliatory DOS			3	3	2			1						
d	Staff ignore complaints			2	1				2						
e	Theft by staff				1										
2 a	Other guests	5	5	3	3	1									
b	Staff pose a threat			5	2				1						
c	Facility is unsafe														
3a	Restrooms, Cleanliness	2	1	1	1										
3b	Hygiene supplies														
3c	Generally dirty site														
4	Hygiene products			1	1										
5	Harmful pest products														
6	First Aid, etc.														
7	Drinking water														
8	ADA	4	4			1			1						
9	Good nutrition	2													
10	Dietary options														
11	No smoking					1									
12	Clean bedding														
13	Quiet time/ Sleep	2	1			1									
14	Daytime access to beds														
15	Storage			1	1	2									
16	Electric outlets														
17	Notice re repairs														
18	Phone availability														
19	22 inches between beds					1									
20	Postings in Spanish														
21	Translation services														
24	Denial of Service > 5PM														
25	Employee badges														
26	Transportation available														
28	Laundry														
29	OSHA														
30a	Training - hand washing	7	7												
30b	-Food handling														
30c	-Emergency procedures														
30d	-Aggressive clients			2											
30e	-Mental health issues			1	1										
30g	-ADA requirements			1		1									
30h	-Shelter training manual			5	1	3									
30i	-Cultural humility			4											
Total		33	33	41	20	21			7						