



City and County of San Francisco

# Shelter Monitoring Committee

## MEMORANDUM

**TO:** Shelter Monitoring Committee  
**FROM:** Committee Staff  
**DATE:** April 12, 2026  
**RE:** **March 2026 Staff SOC Report**

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### Client Complaints

Seven formal complaints were submitted through the SMC to City shelters in Marh 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.*

### Lower Polk TAY Nav Center (86)

**Submitted to SMC: 2/27/26 Sent to shelter: 3/27/26 SMC received response: 1**  
Standards of Care (SOC) Allegedly Violated: 1, 13

### Allegation 1 (SOC 1, 13)

- According to the complainant, there have been ongoing issues with staff conduct and operational practices impacting on the complainant's ability to maintain employment and meet basic daily needs. She reports having previously spoken with supervisors regarding her work schedule and was assured that staff would allow her reasonable access to prepare for work when needed. However, despite those assurances, she was recently denied access multiple times, due to cleaning. These repeated refusals have interfered with her ability to get ready for work on time. In addition, the complainant reports that staff members frequently go on break at the same time, which results in the entire second-floor café being closed. The café is supposed to operate 24 hours, yet there have been multiple nights when it has been closed by the time the complainants return from work. When this happens, the only available place to eat is a small table located just a few feet away from the bathrooms and showers on the sleeping floor. The complainant reports experiencing ongoing rude and dismissive treatment from certain staff members, which contributes to a hostile and unsupportive environment. The complainant reports that she was awakened by staff spraying something near her bed.
- *The shelter responded they try to keep access issues to a minimum, though this can happen when safety and health concerns take precedence. Lysol or similar may have been sprayed. They promised to ensure that guests are notified beforehand if this is necessary again.*

### MSC-South (87)

**Submitted to SMC: 3/9/26 Sent to shelter: 3/16/26 Response received: 4/8/26**  
Standards of Care (SOC) Allegedly Violated: 1, 30

### **Allegation 1 (SOCs 1, 30)**

- The client stated she had become intimately involved with a Case Manager. This employee wanted to take advantage of her, as she has other clients. The complainant attempted to explain these concerns to management; however, the employee is himself in an even more inappropriate relationship with her. He intervened aggressively, threatening the complainant with physical violence. She acknowledges she responded in kind, but other clients are vulnerable and suffer at his hands. She believes the site director tolerates this. The complainant says she has seen this supervisor “playing with himself” sexually as he sits observing clients.
- *The shelter could not find any evidence or person who could substantiate the claims. They pointed out there was an Immediate Denial of Service document stating, “[Client] continued to tell her [staffer] ‘Don’t go home tonight, I swear I’m going to kill your lying ass’ and refused to leave and continued to launch at staff and [supervisor]. Staff and security had to intervene.” The supervisor, and experienced employee, was so stressed out “he had to take a leave of absence.”*

### **Next Door (88)**

**Submitted to SMC: 3/9/26    Sent to shelter: 3/13/26    SMC received response: 3/17/26**  
Standards of Care (SOCs) Allegedly Violated: 3, 8, 17

### **Allegation 1 (SOCs 3, 8, 17)**

- The complainant-client asserts that restroom stalls, including those designed to meet ADA requirements, are often offline with no notice as to the status of repairs. Soap dispensers were removed. “Things break down a lot. The ADA toilet by the elevator is down more than it is ever up. Never any signs ever to when it will be fixed. They just put lots of tape across the stall door saying do not enter then wait for enough complaints sometimes weeks or even months.” The complainant also reports “the ADA shower has lots of mold on upper portion of the walls” and “it has been that way for over a year.”
- *The shelter replaced the soap dispensers. They say the complaint exaggerates the length the restroom has been down. No ADA or standard restroom/shower has been offline for more than a couple of weeks at a time. This is usually due to parts backorders. When staff is notified of a broken stall, they immediately place a sign and tape off the door. This tape is necessary because some guests disregard the signs; using a broken restroom leads to overflows and unsanitary conditions that are harmful to both staff and guests. They recently power-washed all showers and purchased some paint to cover stains. Staff cleans all facilities twice daily, seven days a week. For any ADA guest, they offer the option of a bed change to a different floor so they can access working ADA showers and restrooms if one is temporarily offline. They promised to implement a follow-up protocol, i.e., they will check the status of all outstanding work orders 3 times per week. The manager says he is “actively pushing HSH Maintenance personnel to ensure all repairs are resolved as quickly as possible.”*

### **Bayview Navigation Center (89)**

**Submitted to SMC: 3/14/26    Sent to shelter: 3/16/26    SMC received response: 3/18/26**  
Standards of Care (SOCs) Allegedly Violated: 3, 29, 30

### **Allegation 1, SOC (29, 30)**

- According to the complainant, another shelter guest fell from his bunk and sustained a head injury. San Francisco Fire Department (SFFD) responded and treated the individual. After emergency personnel left, the complainant reports that blood remained in the area and that the manager made no

immediate effort to sanitize the space. The complainant states that after waiting approximately 30 minutes, he requested cleaning supplies due to concerns about the condition of the dorm. The complainant reports that he cleaned the area himself. (Staff from Dorm D, who had provided the cleaning supplies, later returned and mopped the area.)

- *The shelter responded that staff prioritized the immediate care and stabilization of the injured guest to prevent further harm. Immediate cleanup of the affected area was not feasible without compromising the care being provided to the injured guest. Emergency medical personnel arrived before staff were able to begin cleaning the area. In accordance with safety and procedural priorities, staff waited until medical personnel had completed their assessment and care before proceeding with cleanup.*

### **Allegation 2, SOC (3)**

- According to the complainant, the restrooms and dormitory are not being properly maintained. The complainant reports that feces have remained on the floor, walls, and ceiling of the men's restroom for days without being cleaned. The complainant states that despite previously reporting the issue and providing a photograph to staff, the same stain remained visible days later. The complainant included photographs.
- *The shelter manager reported that the area affected, a single shower, went unattended to for at most two days. It was missed. When it was brought to the attention of the facilities manager, it was cleaned promptly. They took "full accountability for not conducting a sufficiently thorough inspections" and recognized that "this does not meet expected standards." They promised that "moving forward, there will be more rigorous and frequent restroom checks to ensure all areas are properly inspected." Additionally, the facilities team will go back to recording their completed tasks through each shift to better control who is responsible should something like this occur in the future. Finally, they are hiring additional janitors.*

### **Division Circle Navigation Center (92)**

**Submitted to SMC: 3/23/26    Sent to shelter: 3/23/26    SMC received response: 3/30/26**  
Standards of Care (SOCs) Allegedly Violated: 1, 15

### **Allegation 1, SOC (1, 15)**

- According to the complainant, on 03/17/2026, site management informed residents that bed assignments would be changed. As part of this process, guests were required to relocate their personal belongings to lockers corresponding with their new bed numbers. The complainant stated that he complied with this directive on 03/18/2026 by removing all of his belongings from his previous locker and placing them into the newly assigned locker. After completing the move, the complainant notified dorm staff that he had followed the instructions. The following day, the complainant left the facility for a scheduled dental appointment. Prior to leaving, he stated that he informed a site supervisor, as well as all the front desk staff, that he had already completed the required locker change. Upon returning to the facility, the complainant reported that he discovered his lock had been cut, and his belongings had been removed, placed into a bag, and left outside in the sun and heat. When he approached the on duty supervisor, she misunderstood or ignored his explanation. The complainant further stated that when he asked whether his belongings had been monitored, given that they included valuable items such as credit cards, a laptop, and a tablet, the supervisor responded, "No, we're not going to watch your stuff, we don't care about that stuff!"
- *The shelter responded that the complainant took it upon himself to move his belongings from his previous locker prior to March 20, 2026, despite notice that this is when this was the date that it*

*would take place, and he had not been instructed to do so. Complainant had his belongings removed and stored by the Supervisor's Office so that they could return belongings to guests that had their belongings removed from their previous lockers. Complainant's property was returned to him on March 20, 2026 after he inquired. They state he "filed no report or made anyone aware of any possible damage until March 23, 2026." He also "failed to timely notify them of possible damage to his electronics so that there was an opportunity to inspect the electronics to verify any damage may have been sustained due to being outside."*

### **Oasis (93)**

**Submitted to SMC: 3/23/26 Sent to shelter: 3/25/26 SMC received response: 3/26/26**  
Standards of Care (SOCs) Allegedly Violated: 1

#### **Allegation 1 SOC (1):**

- According to the complainant, he was attempting to bring food to his pregnant partner. He asked if he could briefly park in the street-level area of the site's covered lot to take the large package of food and drinks up to his room. Security gave him the OK; however, another staffer came out and began aggressively questioning him and threatening him with a DOS. He had a handicapped sticker and was only going to be there for a few minutes, but staff seemed clearly predisposed to find fault with his behavior. After grudgingly being again given permission, he approached the elevator, but a supervisor arrived and said, "We need to talk." This employee was one who had been harassing the complainant for some time, e.g., conducting frequent, unnecessary room inspections, using unprofessional language and disparaging him. He stepped in front of the client and grabbed his elbow to prevent him from entering the elevator. The client reacted without thinking, striking Charles with his elbow. However, he wanted to make it clear that staff initiated physical contact. He was given an immediate denial of service. He was ordered to depart immediately and not given paperwork or information about how to appeal. Staff also decided the family dog had to leave as well. This, the client believes, was done as another way of getting at him. Staff were quite blatantly looking for a way to kick him out and intentionally escalated the situation. In fact, he heard one of them say, triumphantly, "Now we've got him." A witness, a friend of the complainant, told SMC he saw the unprofessional and aggressive behavior of staff in the covered parking area and then saw the assault by Charles, as he looked in from the street through the front office area windows. [This does not seem easy to do, give the layout.]
- *The shelter responded that their Program Agreement states that only registered household members are permitted on the property, including the parking garage and common areas. On the date of the incident, the complainant arrived on site with an unapproved individual, who he identifies in the complaint as a "witness." This individual was not a registered guest and therefore could not remain on the property or in the vehicle parked in the upstairs garage. Staff were required to address this violation and request that the individual and/or vehicle leave the premises. The complainant requested to temporarily park in the upstairs garage. While security initially allowed brief access, staff intervened because the garage is an active, high-traffic area used by families, children, and employees, and the presence of an unauthorized guest in the vehicle required immediate correction. Staff were acting within policy to ensure safety and compliance. They say "Oasis conducts three wellness checks per day, 365 days per year, with two staff members present for each round. This means multiple staff interact with each household daily." The complainant had previously received a written warning for excessive items in the room, which limited safe movement and violated space and fire-safety expectations, a warning for leaving items in the garage instead of returning them to his vehicle, and a warning regarding the family dog, which is required to be muzzled at all times due to*

*the presence of children in the facility. They argue their interactions were not targeted or excessive. As for the dog, the head of household was pregnant and due to give birth at any time. Staff had concerns about the dog being left alone in the room, as the program does not have the capacity to care for or monitor pets in the absence of the owner. Their decision to require it to go with the complainant when he departed the shelter was not punitive. They “maintain a zero-tolerance policy for violence or physical aggression, consistent with HSH expectations and the Standard of Care. During the interaction in the lobby, staff approached the complainant to address the program violation involving the unauthorized guest. The complainant declined to follow the instructions regarding the removal of the vehicle and/or the unauthorized individual and indicated he would proceed as he wished and ultimately made physical contact and struck the staff member. Regardless of intent, any physical contact toward staff constitutes a violation requiring immediate action. They acknowledged that the complainant stated he did not receive paperwork and promised to review this “to ensure proper documentation is consistently provided.”*

### **Oasis (95)**

**Submitted to SMC: 3/26/26 Sent to shelter: 3/27/26 SMC received response: 4/6/26**  
Standards of Care (SOCs) Allegedly Violated: 1

### **Allegation 1 SOC (1):**

- The complainant reported she went to the kitchen to request assistance heating food for herself and her 1-year-old daughter, stating she had not eaten all day. She explained that she had been occupied, and needed to eat due to a serious medical condition. According to the complainant, upon entering the kitchen, she encountered a member of the shelter staff and attempted to explain her need, he interrupted, stating, “we’re making dinner,” and told her to return later. When she attempted to continue explaining, she reported he cut her off and told her to “come at the right time.” They began arguing. The complainant had prior negative interactions with the same staff member, including being told she needed to “put a bra on.” She stated she is breastfeeding and does not have access to an appropriate bra. During the interaction in the kitchen, she referenced this prior incident, stating, “You had no problem talking to me about putting a bra on.” He responded that she was being inappropriate. The complainant reported that during the interaction she began to visibly shake, which she saw as a warning sign of an impending seizure. She told the staffer and said, “If you don’t want to make my food, somebody else will,” and left to take her medication. According to the complainant, another staff member assisted in de-escalating the situation and accompanied her back to the kitchen. She ultimately returned to her room to take her medication. The complainant noted that other staff members had no issue assisting her with heating food. She stated “This is not the first problem with [redacted],” and indicated that if similar issues occur in the future, she will prepare her own meals if he is the only staff present. Staff are expected to treat clients with respect and professionalism, including demonstrating awareness and sensitivity to gender differences and biological needs. Comments regarding a client’s undergarments are inappropriate and may cause discomfort, particularly when made by male staff toward female clients. In a family and children’s shelter, where breastfeeding is common, staff should not impose expectations that fail to account for the practical and medical needs of nursing mothers.
- *After speaking directly with the guest, the staff involved, and additional team members who were present or aware of the situation, the shelter manager expressed concern and stated they had apologized to the guest. “Regardless of operational constraints or timing issues, our responsibility is to communicate with professionalism, empathy, and clarity especially when a guest expresses a medical need or heightened vulnerability.” They found that at the time of the incident, staff were in the*

*middle of a scheduled meal-prep period with limited microwave access. “Staff were attempting to follow our food-safety process, which includes removing items from the freezer, heating them in sequence, and ensuring all guidelines are followed.” Be this as it may, they recognize that the way information is communicated matters just as much as the process itself. “Even when staff are unable to fulfill a request immediately, they are expected to explain the situation respectfully and let the guest know they will be assisted shortly. In this case, that expectation was not met.” They also reviewed the guest’s concern about a previous comment related to attire. As a family shelter that houses men, women, and children of all ages, they do have guidelines for appropriate attire in common areas. However, staff must communicate these guidelines with sensitivity, respect, and awareness of individual circumstances, including breastfeeding. They agreed that the wording used previously was inappropriate. They say they have held staff accountable and provided retraining on trauma-informed communication, guest engagement, and appropriate language, especially in interactions involving women, breastfeeding parents, and guests with medical needs. Staff were reminded they can proactively offer support during wellness checks including water, toiletries, and food so that new mothers or guests who are unwell do not need to leave their rooms if they are uncomfortable or unable to do so. Supervisors have conducted follow-up checks to ensure this protocol is being implemented consistently and that guests are aware of the support available to them.*

**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							2	
711 Post/Ansonia	250 beds							1						1	
Baldwin	179 beds	1	1	2										4	
Bayshore Nav	128 beds	2						1						3	
Bayview Nav	203 beds			1				2	1	1				5	
Gough Cabins	70 rooms														
Central Waterfront Nav	60 beds														
Compass Family UAV	130 beds	2												2	
Dolores Street	92 beds			1		1	2							4	2
Division Circle Nav	186 beds		1		2	1	1		1	1				7	1
Ellis Semi-Congregate	130 beds			1		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							1	
Interfaith Winter Shelter	30-80 bed														
Lark Inn	36 beds														
MSC South Shelter	327 beds		2/2	2/1	1		2	1		1				9 <sup>1</sup>	3
Lower Polk TAY	75 beds				1				1	1				3	
Mission Cabins	68 beds		1	closed										1	
Monarch	93 beds										Closed				
Next Door	334 beds		2			2	1		1	1				7	
Oasis Family	54 beds			1	1					2				4	
Sanctuary (ECS_	200 beds		1	2	4									7 <sup>1</sup>	
Taimon Booten	75 beds	2				1								3	
AWP Drop In	30 beds			2/1										2	1
A Woman’s Place	25 beds								1					1	
<b>Total</b>		9	9	13	9	8	8	5	5	7				73	9

\*Late responses are in red      <sup>1</sup> Multiple complaints from the same client(s)

Standard of Care	Number of allegations of violations of this Standard

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	6	3	1	2				53	
b	Disrespect for property			4	2	4	1	1	1	1				14	
c	Bad/Retaliatory DOS			3	3	2		2	1	2				13	
d	Staff ignore complaints			2	1			1	2					6	
e	Theft by staff				1			1						2	
2 a	Other guests	5	5	3	3	1	1			2				20	
b	Staff pose a threat			5	2		1	2	1					11	
c	Facility is unsafe									1				1	
3a	Restrooms, Cleanliness	2	1	1	1		2							7	
3b	Hygiene supplies														
3c	Generally dirty site						1							1	
4	Hygiene products			1	1									2	
5	Harmful pest products														
6	First Aid, etc.														
7	Drinking water														
8	ADA	4	4			1		1	1	1				12	
9	Good nutrition	2												2	
10	Dietary options														
11	No smoking					1									
12	Clean bedding														
13	Quiet time/ Sleep	2	1			1				1				5	
14	Daytime access to beds														
15	Storage			1	1	2		2		1				7	
16	Electric outlets														
17	Notice re repairs						1			1				2	
18	Phone availability														
19	22 inches between beds					1								1	
20	Postings in Spanish														
21	Translation services														
24	Denial of Service > 5PM							1						1	
25	Employee badges						1							1	
26	Transportation available														
28	Laundry						1							1	
29	OSHA									1				1	
30a	Training - hand washing	7	7											14	
30b	-Food handling														
30c	-Emergency procedures														
30d	-Aggressive clients			2										2	
30e	-Mental health issues			1	1			1						3	
30g	-ADA requirements			1		1								2	
30h	-Shelter training manual			5	1	3				2				11	
30i	-Cultural humility			4										4	
<b>Total</b>		<b>33</b>	<b>33</b>	<b>41</b>	<b>20</b>	<b>21</b>	<b>15</b>	<b>15</b>	<b>7</b>	<b>15</b>				<b>200</b>	

## **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 4 was filled 5/10/2026!]

**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](mailto:shelter.monitoring@sfgov.org) for more information. the Homelessness Oversight Commission has a nominations subcommittee charged with recommending appointments to the SMC. 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

### **FY2025-2026 Tentative Schedule of Upcoming SMC Meetings:**

**June 17, 2026**