City and County of San Francisco

Shelter Monitoring Committee

MEMORANDUM

TO: Shelter Monitoring Committee
FROM: Committee Staff
DATE: October 15, 2024
RE: **September 2024 Staff SOC Report**

Client Complaints

There were six formal complaints were submitted through the SMC in September 2024.
****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 responses 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.*

MSC-South

Client 1

Submitted to SMC: 8/30/24 Sent to shelter: 9/4/2024 SMC received response: 9/10/24

Alleged Standard of Care (SOC) Violations:

- SOC #13 (Make the shelter facility available for sleeping at least 8 hours per night …)

Allegation 1 (SOC 13):

- The client said noise is an issue…particularly during the hours designated for sleeping." Guests have been repeatedly told that headphones are required, but staff members do not enforce this. Many guests continue to do use electronic devices and converse with neighbors after lights out.
- *Shelter management stated they shared the allegations made and explained expectations. They covered SOC 13 and believe staff will improve in their efforts to fulfill this requirement.*

Client 2

Submitted to SMC: 9/15/24 Sent to shelter: 9/17/2024 SMC received response: 9/24/24

Alleged Standard of Care (SOC) Violations:

- SOC #1 (Respect…)
- SOC #31 (… all-staff mandatory trainings… cultural humility, including sensitivity training regarding homelessness…)

Allegation 1 (SOC 1):

- The complainant reports going up to the service desk in the community room to ask for paper towels or tissue. The staff informed him there were no paper towels and so the guest then requested some tissues as they were visible. Staff stated, "these tissues are for employees only." One staffer did give the guest some, but another stated, "Why do you keep harassing the workers?"

- *Management spoke with the complainant and assured him he would coach staff. Normally, the two get along quite well. He just felt that "in this instance he was a bit insensitive."*

Allegation 2 (SOCs 1, 31):

- Soon thereafter the guest had another incident with the same staff member. The area in which the guest sleeps is located in the far back of corner of a section of the second floor. It tends to get hot and the guest went to the three staffers on duty to request permission to open windows. The staff member who the guest originally approached told him to ask the staff member sitting at the staff desk. His response was simply "no," without explanation. The guest had to go to a supervisor. This seemed unnecessary. Then the guest then heard this staff member saying, "He's a f***ing man, not a lady, he just wants to bother us..."
- *The staffer stated he did not make the statements that he has been accused of making. Management conveyed to him that sometimes our tone can give a guest the feeling of being seen as a problem rather than a client. He also stated that because of his cultural background, he may sometimes seem to be insensitive, but this is just the way he speaks. He promised to apologize to the client.*

A Woman's Place

Client 1

Submitted to SMC: 9/1/24 Sent to shelter: 9/4/2024 SMC received response: 9/13/24

Alleged Standard of Care (SOC) Violations:

- SOC #1 (Respect…)
- SOC #31 (… all-staff mandatory trainings…proper food handling and storage …)

Allegation 1 (SOC):

- The complainant noticed sanitation concerns regarding food storage and cleanliness. Although "the cook does his best to prepare the food, it is often left out all day." The complainant further reports that there are dirty mops and rags left all around the food and in the kitchen where the food is prepared and that food boxes are left out to the point of them becoming rotten and has noticed a variety of pest infestations.
- *The shelter responded that all kitchen staff "have current ServSafe certification and all other staff have completed SFDPH Standards of Care Safe Food Handling Training." All food is put away after mealtimes and food deliveries are handled as quickly as possible, with a focus on getting frozen and refrigerated products away first. Chemicals and any items for cleaning are stored/kept away from food preparation areas and food storage. Staff are working with the facilities team and pest control professionals to regularly remediate any pest issues. Since this complaint was filed, staff have set up weekly pest control appointments to ensure that there are no mice or rats. They also went through the kitchen and the rest of the basement to seal up any cracks and holes. Staff monitor traps placed by pest control.*

Bayview Navigation Center

Client 1

Submitted to SMC: 9/6/24 Sent to shelter: 9/9/2024 SMC received response: 9/9/24

Alleged Standard of Care (SOC) Violations:

- SOC #3 (Cleanliness)
- SOC #31 (Training…)

Allegation 1 (SOC 3):

- Client complained that he had to be taken to the ER by ambulance due to the negligence of the shelter. He was given fentanyl without his knowledge. Clients freely "smoke crystal" after the day shift departs, including inside the shelter. They freely use meth and fentanyl within 200 feet of the entrance. Staff ignore these violations of the shelter's procedures. This is making the shelter unsafe. There are guests who deal dangerous drugs and may make them more so by lacing in fentanyl. When he began to suffer an adverse reaction, he asked for an ambulance. Staff took ten minutes to request one.
- *The shelter responded that their care monitors do walkthroughs, and wellness checks every ten minutes. When they see someone smoking inside or in front of the property, they immediately write a shelter warning. Case managers meet with such guests the next day and remind them again that they must be 200 feet away from the facility. They encourage users to stay with another individual. They keep Narcan on hand. Staff tries to ensure that guests adhere to the rules; however they are only allowed to write people up if staff see it live. They have community meetings every month and we give the guests a time to voice their concerns with neighbors. Staff encourage guests not to accept medications from other guests but to see the nurses onsite if they need medication.*

Allegation 2 (SOC #31):

- The shelter does not follow proper food handling procedures. On Labor Day weekend, they ran out of food and only one meal was available on at least one day. The kitchen is very frequently closed beyond the posted times. Staff routinely extend their breaks and brazenly state that they will take all the time they need
- *They had more than enough food during Labor Day weekend. The did run out of milk and juice, but that was quickly resolved.*

Division Circle

Client 1

Submitted to SMC: 8/22/24 Sent to shelter: 9/12/2024 SMC received response: 9/19/24

Alleged Standard of Care (SOC) Violations:

- SOC #1 (Respect)
- SOC #2 (Safety…)
- SOC #3 (…hire janitorial staff to clean shelter on a daily basis…)
- SOC #8 (ensure case management services go to those shelter clients most in need…)
- SOC #12 (Provide shelter clients with… one clean pillow…)
- SOC #15 (Provide shelter clients with pest-free, secure property storage …)
- SOC #31 (Training … in case of disaster, fire, or other urgent health or safety risk …)

Allegation 1 (SOC #1):

- The complainant has regularly asked staff in the dorm he sleeps in to adjust the A/C. Some of them tell him they cannot turn it off. However, they clearly can, because on other occasions other staffers did so within five minutes of being asked. Many people, including staff, say they

are also very cold. The complainant believes he has been harmed by the "constant blowing cold air right on [his] bed." Furthermore, the client has repeatedly asked the site manager to address this systemic problem. There has been zero improvement. He has not even responded to the client's clearly articulated concerns.

- *The shelter has been experiencing issues with the heating/air conditioning units and have been working with HSH Facilities to correct the issues. Staff and guests accessing the thermostat may turn the heat up too high or too low, causing the heating/air conditioning units to fail.*

Allegation #2 (SOCs 2, 3):

- The client states there is "open drug use all night long in the bathrooms"; and feces is "smeared around the toilets and urine is regularly visible all over the floors."
- *Staff members complete wellness checks on a continual basis and are also supported by security personnel. Maintenance workers complete cleaning of the bathrooms and showers between the hours of 5:00 a.m. – 6:00 a.m., 2:30 p.m. – 3:30 p.m., and 10:30 p.m. – 11:30 p.m. Maintenance workers conduct periodic checks of the bathrooms and respond to any urgent matters that require immediate cleaning assistance.*

Allegation #3 (SOC 1):

- The client asserts that he lost valuable property due to the negligence of staff. When he first arrived at the site on 7/3/24 he asked about his other suitcase. Staff said, "it shouldn't be a problem," but he was "demeaned and ridiculed" by management in front of employees at the front desk.
- *The shelter makes every attempt to store excessive property for guests in their outside storage container. The guest attempted to bring in a second suitcase, and was advised that he could only have one suitcase at his bed. He was offered the opportunity to store the second suitcase in the outside container. There is no known negligence of staff as it relates to lost property.*

Allegation #4 (SOC 8):

- The client believes he was incorrectly told he could not apply for GA benefits in San Francisco for a period of time. As a result of this misinformation, he lost money.
- *A representative from San Francisco County Adult Assistance Program met with the guest. Based on this discussion, it appears he was discontinued from Marin County General Assistance, as the guest no longer resided in Marin County. A subsequent case management conversation with guest and site manager took place. The guest was dissatisfied with the amount he was receiving through San Francisco General Assistance and was looking for employment. He was provided with relevant information.*

Allegation #5 (SOCs 1, 2, 31):

- The client reports he felt feverish and asked for a COVID test. He was kept waiting and treated rudely. He was literally locked in a room. Then they told him he had tested positive, but was not reassured, told what to expect, or treated with anything approaching respect, much less kindness. Only when the on-duty UCSF physician called, was he offered a hotel (I&Q) option.
- *The guest was placed in isolation after experiencing CoViD-like symptom. Rules currently in effect necessitate a referral to an isolation and quarantine site for a minimum of five days. The on-duty staff completed the referral and waited for a response confirming the transfer. As it was over the weekend, there was a delayed response. The guest asked to have 911 called and they did accommodate his request. He was transferred to an isolation and quarantine site after he was discharged from UCSF.*

Allegation #6 (SOCs 1, 15, 31):

- The client was quarantined, locked in a room (at the I&Q site) with "no toilet paper or soap," and subjected, he states, to abuse by the staff. From there, he contacted the supervising Case Manager at Division Circle to ask about things he needed temporarily. He was instructed to provide a list of what he needed, and they would bring them to him. Meanwhile, all his belongings were bagged and put in storage. In the end, because of the shelter's negligence, he returned to find that many of his belongings had been thrown out or otherwise lost, including new shoes in their box. Also, a "pair of prescription eyeglasses with a value of at least $360" were broken. When the complainant went to management about the various elements of unacceptable service, he did not respond other than to say, "you can complain to Shelter Monitoring."
- *SVDP-SF will not respond on behalf of "Adante" as this is a separate organization that operates the I&Q site. Due to the guest testing positive for COVID, they asked that he not return on site and made every effort to gather what belongings he would need while away. The guest did not specifically respond to what items he needed. Property was bagged by staff after he was transported to "Adante," and a hold was placed on his bed. The guest made a complaint that property was either lost or damaged. A request was made to the guest via email requesting documentation and photographs to substantiate this claim. He has not provided this.*

Allegation #7 (SOC 12):

- The client claims he went without a pillow for a month.
- *The guest was advised that there are pillows available at the front desk. For some reason, he did not avail himself of this. Division Circle does provide guests with a pillow if they are in need, in accordance with the Standard of Care.*

Client 2

Submitted to SMC: 9/18/24 Sent to shelter: 9/19/2024 SMC received response: 10/3/24

Alleged Standard of Care (SOC) Violations:

- SOC #1 (Respect…)
- SOC #15 (…property storage…)

Allegation 1 (SOCs 1, 15):

- The complainant reports that a staffer shouted out "in a demeaning way" to all the guests (in reference to the scheduled pest treatment), "We will move your stuff and sweep, so it will be thrown out if it's on floor!" He had packed 3/4 of his things by 8:30 a.m. and then had to leave briefly. He came back at 9:40 a.m., only to find they had thrown the rest of his possessions into bags, including valuables he had placed under his. His property was bagged without his permission. The site specifically called for guests to be ready at 10 a.m. for the pest treatment. There was no reason to bag the remainder of his things before that time. He was not able to get his heart medication, i.e., he was not given time to find it. Partially due to this, and due to the stress of been again so disrespected, he landed at the ER that afternoon. He has no confidence that staff are concerned for his rights, dignity, or health and safety.
- *The shelter stated that Day Shift staff goes around at 8:30 a.m. to remind the guests to bag all of their personal by 9:30 a.m. Given that there are 186 guests at Division Circle Navigation Center, there is a need to begin bagging property for guests that are not on-site prior to closing of the dormitories at 10:00 a.m. The complainant left at 8:42 a.m. and returned at 9:45 a.m.. Given that*

an hour lapsed between the time he left and the time returned, staff had no knowledge of the complainant returning and bagged the remainder of his property. The complainant made no request to retrieve medication to her on this date. If he had made this request, staff would have worked with him prior to having the dormitory area closing at 10:00 a.m.

August 2024 Client Complaints by Standard

Standard of Care	Number of allegations of violations of this Standard
Standard 1: Treat all clients equally, with respect and dignity…	7
Standard 2: Provide shelter services in an environment that is safe …	3
Standard 3: Supply and clean restrooms…	3
Standard 8: Provide shelter services in compliance with the ADA…	2
Standard 9: Engage a nutritionist…	
Standard 12: Clean bedding…	2
Standard 13: Make sleep possible…	1
Standard 15: Storage…	3
Standard 17: Maintenance problems…	
Standard 31: Training…	6

Note that each complaint can include alleged violations of more than one SOC or multiple violations of the same SOC.

*Total Client Complaints FY 2024-2025**

Site	Site Capacity	7/24	8/24	9/24	10/24	11/24	12/25	1/25	2/25	3/25	4/25	5/25	6/25	Total FY24-25 Red indicates late response		Complaints per 100
711 Post/Ansonia	250 beds	**1**												**1**		=
Baldwin	179 beds	**2**	**1**											**3**		
Bayshore Nav	128 beds	**1**												**1**		
Bayview Nav	203 beds	**1**		**1**										**2**		
Embarcadero Nav	200 beds	**1**												**1**		
Gough Cabins	70 rooms															
Central Waterfront Nav	60 beds															
Cova Hotel	90 beds															
Division Circle Nav	186 beds			**2**										**2**		
Ellis Semi-Congregate	130 beds															
Embarcadero Nav Cntr	200 beds															
Hamilton Emergency	27 fams	**1**												**1**		
Harbor House Family	30 fams		**1**											**1**		
Hospitality House	22 beds															
Lark Inn	36 beds															
MSC South Shelter	327 beds	**2/1**	**1**	**2**										**5**	**1**	
Monarch	93 beds															
Next Door	334 beds															
Oasis Family	54 beds	**1**												**1**		
Sanctuary	200 beds	**1**	**1**											**2**		
A Woman's Place	25 beds	**2**		**1**										**3**		
Total		**13**	**4**	**6**										**23**	**1**	

*Late responses are in red

Staff Update and Committee Membership

Membership (Admin. Code Sec. 30.305)

There is currently **one unfilled seat** on the Shelter Monitoring Committee:

> **Seat 1 -** Must be homeless or formerly homeless who is living or has lived with their homeless child under the age of 18. (These requirements are being revised in accord with the changes proposed by the SMC in 2022.)

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

Legislation

On September 10, the BOS's Rules Committee accepted a proposed Ordinance amending the Administrative Code to alter the frequency of site visits; require the Committee to establish in its bylaws the threshold number of complaints and/or out-of-compliance findings during a year that would trigger additional site visits; **revise eligibility criteria for Seat 1** on the Committee; revise the Standards of Care for City Shelters by establishing requirements for shower stalls with working hot and cold
water controls, minimum passing space for sleeping units that are not up against a wall or partition, and signage posting regarding availability of translation services; eliminate the minimum shelter stay requirement for single adult reservations; revise the complaint process and investigation procedure; and updating some language in the ordinance.

FY2024-2025 Upcoming Meeting Calendar:

Nov 20
Jan 15
Feb 19
Mar 19