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For Mentally Ill, Death and Misery

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Randolph Maddix, a schizophrenic who lived at a private home for the mentally ill in Brooklyn, was often left alone to suffer seizures, his body crumpling to the floor of his squalid room. The home, Seaport Manor, is responsible for 325 starkly ill people, yet many of its workers could barely qualify for fast-food jobs. So it was no surprise that Mr. Maddix, 51, was dead for more than 12 hours before an aide finally checked on him. His back, curled and stiff with rigor mortis, had to be broken to fit him into a body bag.

At Anna Erika, a similar adult home in Staten Island entrusted by the state to care for the mentally ill, three other residents had previously jumped to their deaths when a distraught Lisa Valante, 37, sought help. But it was after 5 p.m. and, as usual, the residents, some so sick they cannot tie their shoes, were expected to fend for themselves. No one stopped Ms. Valante, then, from flinging herself out a seventh-floor window.

Sometimes at these homes, the greatest threat can be the person who sleeps in the next bed. Despite a history of violent behavior, Erik Chapman was accepted at Park Manor in Brooklyn. After four years of roaming the place with a knife, Mr. Chapman stabbed his roommate, Gregory Ridges, more than 20 times. At last, Mr. Chapman was sent to a secure psychiatric facility. Mr. Ridges was sent to Cypress Hills Cemetery at the age of 35.

Every day, New Yorkers come face to face with the mentally ill who have ended up on the streets since the state began closing its disgraced psychiatric wards more than a generation ago. Mr. Maddix, Ms. Valante and Mr. Ridges were among thousands more who ended up in dozens of privately run and state-regulated adult homes in New York City.

A yearlong reporting effort by The New York Times, drawing upon more than 5,000 pages of annual state inspection reports, 200 interviews with workers, residents and family members, and three dozen visits to the homes show that many of them have devolved into places of misery and neglect, just like the psychiatric institutions before them.

But if The Times's investigation found that the state's own files over the years have chronicled a stunning array of disorder and abuse at many of the homes, it discovered that the state has not kept track of what could be the greatest indicator of how broken the homes are: how many residents are dying, under what circumstances and at what ages.

The Times's investigation has produced the first full accounting of deaths of adult home residents. At 26 of the largest and most troubled homes in the city, which collectively shelter some 5,000 mentally ill people, The Times documented 946 deaths from 1995 through 2001. Of those, 326 were of people under 60, including 126 in their 20's, 30's and 40's.

At two of the largest homes, Leben Home in Queens and Seaport Manor in Brooklyn, roughly a quarter of the 145 residents who died were under 50. The Times's analysis of the deaths used Social Security, state, court and coroner's records, as well as psychiatric and medical files.

The analysis shows that some residents died roasting in their rooms during heat waves. Others threw themselves from rooftops, making up some of at least 14 suicides in that seven-year period. Still more, lacking the most basic care, succumbed to routinely treatable ailments, from burst appendixes to seizures.

Some of the hundreds of deaths undoubtedly stemmed from natural causes and were unavoidable. Studies have found that the mentally ill typically have shorter life expectancies than the general population, because they have difficulty caring for themselves and are more prone to health problems. The average age of death in the overall survey was 63.

There are few extensive studies on death rates of the mentally ill in facilities like adult homes. But Dr. E. Fuller Torrey, a psychiatrist who is a nationally recognized expert on mental illness and mortality, called The Times's analysis disturbing.

"It would certainly suggest a fair number of deaths that were premature," said Dr. Torrey, who is executive director of the Stanley Medical Research Institute in Bethesda, Md., and is familiar with the adult home system in New York City. "There is no question that if these people were getting better care and more skilled care, they would be living longer. And this poor care leading to death is going to cut right across the age population. It also means that people who are 70 are dying prematurely."

In the end, whether the residents were in their 20's or 70's, it is impossible to know just how many of their deaths could have been prevented. The only other accounting of the dead seems to be on Hart Island in the East River, where scores of adult home residents are buried in the mass graves of potter's field.

Officials at the State Department of Health, which regulates the homes, acknowledge that they have never enforced a 1994 law that requires the homes to report all deaths to the state. Asked for records of any investigations into deaths at the homes, the department produced files on only 3 of the nearly 1,000 deaths.

None of the suicides were among the three. Even the fatal stabbing of Mr. Ridges at Park Manor went unexamined by the department. The city medical examiner's office said it had not received a single inquiry in recent memory from state inspectors regarding an autopsy of an adult home resident.

Neither Gov. George E. Pataki nor his health commissioner, Dr. Antonia C. Novello, would comment on The Times's investigation. Their aides said a deputy health commissioner would speak for the administration.

Presented with The Times's findings, the deputy health commissioner, Robert R. Hinckley, said the department would examine "ways to better investigate those deaths that are reported to us."

To that end, Mr. Hinckley said the state would issue a regulation alerting the homes that it would strictly enforce the 1994 law on reporting deaths.

"We want facilities to follow the law, and we are redoubling our efforts to get them to report all deaths," he said.

As of Friday, seven weeks after Mr. Hinckley's promise, the department had still not issued the regulation.

About 15,000 mentally ill adults -- most of them poor, many of them black and Hispanic -- reside in more than 100 adult homes in the state, the majority in the city and its suburbs. Some are now larger than most psychiatric hospitals in the nation.

The reality of the homes is far from what was envisioned. In the 1960's, New York, like other states, decided to shutter or sharply scale back its psychiatric wards, where patients often languished for decades.

When the profit-making adult homes offered to shelter the discharged patients, the state embraced the idea. Federal disability money was used to pay the homes, which would provide meals, activities and supervision. The homes would bring in outside providers for psychiatric and medical care.

The state was responsible for making sure it all went well.

But from the start, problems surfaced. No one knew about them better than the state itself, which for 30 years has issued damning inspection reports and then all but ignored them.

State investigators across those three decades described many of the homes as little more than psychiatric flophouses, with negligent supervision and incompetent distribution of crucial medication. At one, Brooklyn Manor, the staffing was so sparse that a resident was put in charge of the entire place on one evening, a routine 2001 state inspection report shows.

In more than 100 inspection reports from 1995 through 2001, investigators frequently noted filthy and vermin-ridden rooms in some homes, and disheveled and unbathed residents in others. They cited administrators for poor, sometimes fraudulent, record-keeping involving residents' money and care. A 2001 state inspection of Garden of Eden in Brooklyn found the operator to be "routinely threatening residents."

In a 1990 overview of adult homes, the Commission on Quality of Care for the Mentally Disabled, a small state watchdog agency, rated half of the homes that it surveyed in the city as poor. Ten years later, the agency came to the same conclusion.

But the formal reports get at only part of the system's failures, according to The Times's investigation.

The investigation reveals several of the homes to be medical mills where the operators and health care providers pressure residents to undergo treatment -- even surgical operations -- they neither need nor understand in order to earn Medicaid and Medicare billings.

The homes are typically run by businessmen with no mental-health training. A 1999 audit by the State Comptroller's Office aimed at evaluating the regulation of adult homes found that the Department of Health had done little to scrutinize the people it licensed to run them.

The homes are staffed largely by $6-an-hour workers who dispense thousands of pills of complex psychotropic drugs each day. At one home, Ocean House in Queens, social workers said a medication worker was basically illiterate.

The homes are not required to have professional staff on duty overnight. Multiple visits reveal that often only the janitors, and possibly a guard or two, remain.

Nathaniel Miles, a former porter at Surf Manor, a 200-bed home in Coney Island, recounted two scenes last year that he called typical: on one night, he had to stanch the heavy bleeding of a resident who had had a seizure and fallen in a bathtub. Down in the lobby on another night, he had to chase after a woman who had threatened to kill herself and had run from the home.

The notion that residents would be limited to those who might, with help, enter the work force or join a community was abandoned almost from the outset. The state's own files show that the residents include severe schizophrenics, manic-depressives and others who have no hope of achieving self-sufficiency. Visits to the homes reveal that some residents hole up in their rooms for days at a time. Others can be found in smoking rooms or hallways, suffering psychotic episodes. Some are shuttled back and forth to psychiatric wards.

And many, it is clear, do not survive.

At the largest homes, one person died every three to eight weeks on average from 1995 through 2001, The Times's analysis shows. At the 361-bed Leben Home, 14 of the 66 dead were under 50 years old. At the 346-bed Seaport Manor, 24 of the 79 dead were under 50.

"Seaport is no more than a warehouse," a 50-year-old resident wrote to her sister on Christmas Day, 1998. "There are an unusual number of deaths among middle-aged people here."

Less than two months later, the resident scrawled "Evil wins" on the wall of her room, swallowed an overdose of pills and placed a plastic bag over her head, according to toxicology reports from the medical examiner's office and interviews with Seaport workers. The home's report to the state shows that Seaport failed to disclose the true details of her suicide, saying only that she was discovered dead in her bed. The state never looked into it anyway, according to its own files.

To do an inventory of the deaths, though, is to appreciate residents who had passions and triumphs and who had strived to find their own place in the world.

Jonathan Miller, sweet and gentle, traded baseball cards from his room at an adult home in Queens called King Solomon. He died there, of a heart attack, during a heat wave in July 1999. Mr. Miller, 35, was not discovered until the smell brought a worker to his door. The home waited until night to remove his body, workers said, then they cleared his room of the baseball cards he loved. At his wake, his family wept in front of a coffin that had to be closed to hide what had happened to his corpse.

"These people are just given little value by either the state or the adult homes or the mental health providers," said George Gitlitz, who has spent a decade visiting the homes and urging the state to improve conditions on behalf of the Coalition of Institutionalized Aged and Disabled, one of the few advocacy groups for adult home residents. "They are seen as dollar signs -- as property -- and not as human beings."

The sorry history of New York's adult homes and their oversight extends over decades and multiple administrations. And New York is not entirely alone. Other states placed discharged mental patients in similar facilities. In 1989, after surveying homes in several states, a Congressional committee called them "a national tragedy."

Not all the dozens of homes in New York City are disastrous. Some are clean and staffed by kindly people who try to help the mentally ill find their way. Yet all the places are troubled by the same systemic problems, like untrained workers and gaps in supervision.

The homes are also costly. The government spends an average of $40,000 a year on each resident through federal disability and Medicare and Medicaid payments. That adds up to $600 million annually in taxpayer money.

Yet even as public money pours into the system, the government does little to hold the homes accountable. Over the years, few operators have been meaningfully punished, despite amassing records of misconduct, state inspection reports and interviews show. Albany, lawmakers concede, has consistently chosen to avoid the looming question: If you close the homes, where will the mentally ill live?

And so for decades, thousands of them have been living in broken-down former hotels and rooming houses. Police and fire department records make clear that emergency workers are frequent visitors, routinely responding to 911 calls about psychotic episodes, unfettered chaos and dead bodies.

Merciless Season
A Sweltering Summer, Rooms Like Ovens

The summer of 1999 was one of the most oppressive in memory in New York City, day after day of soaring temperatures and pleas from health officials for the public to take precautions.

At the Leben Home for Adults, a brick building on 45th Avenue in Elmhurst, Queens, the rooms could heat up like a furnace. Originally built to house offices for an airline parts factory, the structure is poorly ventilated, making it hotter inside than outside in the summer.

The more than 350 residents at Leben, like many mentally ill people, are vulnerable to the heat because of their medication and poor general health. Most also had no income beyond their modest monthly disability checks, and could not afford to buy air-conditioners or pay the additional fees that Leben's operator, Jacob Rubin, charged to run them.

Mr. Rubin received more than $3 million a year in government money to operate the home, even though state inspections deemed it neglect-ridden. As Mr. Rubin ran the air-conditioner in his office there, closing the door to keep it cool, workers said, many residents went without fans.

It was an exceptionally tough summer for Michael Bonner, who had taken to hiding away in his room for days at a time, with no one at the home trying to coax him out.

Mr. Bonner had schizophrenia and depression and had been in and out of homeless shelters, psychiatric wards and adult homes for much of his 52 years. There had been times when he found stability. He had worked as a porter at La Guardia Airport and as a clerk at a department

store. He had liked to show up at his uncle's home in the Bronx. "Surprise!" he would say before bounding in. But his disease always seemed to win out.

By 1999, it had become overwhelming.

For weeks at Leben that summer, workers said, they appealed in vain to Mr. Rubin to install new air-conditioners and fix broken ones. The rooms were suffocating, and resident after resident was getting sick.

Mr. Bonner remained in his room all day on Aug. 16, when the outdoor temperature reached the mid-80's. At some point, Mr. Bonner's roommate saw that he was in distress and ran into the hallway looking for help. Dennis Lloyd, the director of security and recreation at the time, responded.

"The man is in convulsions, foaming from the mouth," Mr. Lloyd said in an interview. "His body had to be like 108 degrees, 109 degrees, such a fever. It was hot that day. To touch him, oh my God. His body was burning up. When E.M.S. came in, we were ordered to soak towels in cold water, to wrap his body. But it was too late. He died in the hospital."

After working at Leben for 14 years, Mr. Lloyd left last year and took a job at a nursing home. He said he agreed to be interviewed about Leben because he felt the public needed to know about the conditions there.

In Mr. Bonner's case file at Leben, it was scrawled only that he had hyperthermia, a spike in body temperature. His uncle, Nathan Goods, said an administrator had told him that Mr. Bonner had died of a heart attack.

Leben never notified the State Department of Health about the death. That was not surprising. Instead of enforcing the 1994 law requiring the homes to report all deaths, the department asks the homes to report deaths only from "other than natural causes." The homes, which have no medical credentials, get to make that determination, and they usually determine deaths to be natural.

Mr. Goods eventually went to Leben to pick up his nephew's few possessions, which the home had put into a trash bag. "He was just another poor soul who didn't have a family with money who could watch him and protect him," Mr. Goods said.

His death at Leben was not unique, though. July and August were the deadliest months at the 26 adult homes in The Times's survey in four of the seven years. As at Leben, most of the other homes do not run air-conditioning unless residents pay an extra $25 to $150 a month. The operators say the state does not pay them enough to provide it free.

Few months took as great a toll as July 1999, when 17 residents died.

Three weeks before Mr. Bonner died, Stephanie Dinardi, 40, was found by her roommate naked on the floor at Leben and was dead when the ambulance arrived.

But the ambulance workers knew they would be back. "During the summers, we were constantly at Leben for heat cases," said Chris Jute, one of the workers who responded that day.

The state knew the reasons. Psychotropic drugs can reduce sensitivity to heat and the ability to sweat. The mentally ill are also less likely to take precautions, such as drinking fluids, and are prone to diabetes and other diseases aggravated by heat. One of the state's own psychiatrists, Dr. Nigel Bark, found in a study that psychiatric patients had twice the risk of dying during heat waves as the general population. He concluded that the "risk can be eliminated" with air-conditioning and other precautions.

The State Office of Mental Health has provided air-conditioning in the state's psychiatric hospitals for more than two decades. The office, the agency with the most expertise in addressing the needs of the mentally ill, has little role in overseeing the adult homes, which shelter three times more mentally ill people than the psychiatric hospitals.

Asked why the adult homes were not air-conditioned and what precautions were taken by the Department of Health in the summer, Mr. Hinckley, the deputy health commissioner, said regulations required the operators to ensure that residents "remain comfortable" when the temperature is above 85 degrees.

While many hospitals and nursing homes run air-conditioners, Mr. Hinckley pointed out that the state did not require them to do so, either.

Mr. Rubin would not comment. In May 2001, after The Times published two articles detailing malfeasance at Leben, the state forced him to surrender his license and leave the industry. The home, under new management, was recently renamed Queens Adult Care.

Muriel Sachs, who endured a quarter-century at Leben, would not live to see Mr. Rubin go. Ms. Sachs, 71, had respiratory problems and the misfortune of being assigned a room on Leben's third floor, its highest and hottest.

She was a fixture at the home, wandering the halls and showing off an old photograph of herself with a dapper man she imagined was her husband. She had survived a lobotomy and more than two decades in psychiatric wards before the state shut them down. "We have no other alternative than referring her to you," a social worker wrote to the newly opened Leben in 1974.

She would grow old at the home. Then, on July 6, 1999, several things conspired against her in Room A317. The outside temperature hit 101 degrees and Mr. Lloyd, the longtime security director, said the workers on duty that night refused to check on the residents on the third floor because it was stifling.

Room A317 not only lacked air-conditioning. The fan also did not work because the room's electricity had accidentally been shut off, Mr. Lloyd and other current and former workers said.

In the middle of the night, Ms. Sachs got out of her bed, perhaps to seek help. She did not get far. At 6:50 a.m., she was found face down on the floor of her room, dead of heart failure, according to police records.

"She passed away because of the suffocating heat," recalled a former janitor, Arsenio Cabrera, who was on duty that morning.

Mr. Cabrera, Mr. Lloyd and other former Leben workers said they kept silent because they feared losing their jobs. "Everything was covered up," Mr. Lloyd said.

Mr. Rubin notified the Health Department about Ms. Sachs's death, without mentioning the heat, according to department records. A state inspector wrote a note saying that she could not follow up anyway because she was too busy, the records show.

Ms. Sachs was Jewish, and occasionally attended religious services. A group called the Hebrew Free Burial Association will provide a proper Jewish burial in the city for anyone who cannot afford it. It requires a phone call. Ms. Sachs was sent to potter's field. No mourners or headstone or prayers. Only a burial number, 34943.

Threat to Themselves
A Trail of Suicide, A Lack of Answers

Both Melvin Ryan and Lisa Valante had long been besieged by schizophrenia. Their voluminous psychiatric records told of histories of bizarre behavior, of an inability to care for themselves, of periods of depression so relentless they could not pull themselves out of bed for days.

They had already tried to kill themselves when they were sent by a state hospital, Rockland Psychiatric Center, to the Anna Erika home in Staten Island within two months of each other in the late 1990's. Less than two years later at the home -- deemed by the state to be the appropriate place for them to live -- the two would finally succeed in ending their lives.

Mr. Ryan, 51, jumped out a seventh-floor window. Less than three weeks later, Ms. Valante, 37, did the same. They were the third and fourth residents of the home to commit suicide that way in four years. After Ms. Valante's death, the operator of the home installed guards on some windows, he said, but not on others, including the one that Ms. Valante had jumped from.

In the state's headlong drive to make its psychiatric wards obsolete, officials have publicly maintained for 30 years that the adult homes are a satisfactory substitute. The thinking is this: with psychotropic drugs, residents do not need close supervision. They will see therapists regularly, and when a crisis arises, they will be sent to a psychiatric ward.

In the wake of that thinking lies a roll call of suicides that, in recent years, includes but is not limited to:

*Vadim Sapojnikov, 26, who left Park Manor, went to his family's home for a visit and leapt from a fourth-floor window.

*Eliezer Sulsona, 42, Sherri Cohen, 38, and Joan Ciancimeno, 49, who jumped from New Haven Manor, Sanford Home and Park Inn in Queens.

*Robert Tricarico, 41, who leapt from Lakeside Manor in Staten Island.

*Lavar Murphy, 22, and Charles Osdin, 83, who hanged themselves at Wavecrest in Queens and Riverdale Manor in the Bronx.

*Myrna Millington, 61, and Fu Jun Ho, 45, who jumped from Anna Erika before Ms. Valante and Mr. Ryan.

All these suicides went uninvestigated by the state inspectors who regulate the homes, according to their records. Had the suicides occurred at a psychiatric hospital or even a prison, they would have routinely prompted inquiries.

Ms. Valante had been sick since her 20's and was estranged at times from her parents, who live in Florida. As her illness worsened, she often refused to bathe and insisted on wearing only one set of clothing, a printed housedress over a long black outfit.

Mr. Ryan had lived with his elderly parents in Harlem for years, until they could no longer care for him. Despite his battles with schizophrenia and drug abuse, he had the face of a mama's boy, angelic and unlined, and a sinewy body that harked back to his days as a high school track star.

By the time they got to Rockland Psychiatric Center in 1997 and 1998, the two had been hospitalized numerous times after psychotic, often suicidal, episodes, and it seemed clear that their chances of leading stable lives were slim.

Mr. Ryan was put on a suicide watch at one point at Rockland, and often told his psychiatrist that he heard voices threatening to lynch him, according to his treatment records.

Ms. Valante wrote all over the walls of her hospital room, a paranoic graffiti about death and evil. A psychiatrist quoted her in her treatment records as saying, "I wish I could just die and rest in peace and eternity."

Still, Mr. Ryan and Ms. Valante could not remain there forever. The state encourages hospitals to save money by stabilizing patients and discharging them. With few exceptions, New York does not want to provide long-term psychiatric care.

So the two were sent to Anna Erika to stay.

Like many adult homes, Anna Erika has been cited by state inspectors for serious violations in recent years. The home is one of the largest in New York, with 427 beds, including a significant population of elderly people, some without mental illness. But at one point, inspectors charged that it did not have a single qualified case manager to supervise residents, according to a 1999 state report.

The therapists who came to Anna Erika to treat residents did what they could, but there were not enough of them and the home could also easily get rid of them if they complained about conditions.

Soon after Mr. Ryan and Ms. Valante began living there, they hunkered down in their rooms. Over the next year and a half, both had psychotic episodes, were hospitalized and then were determined well enough to return to the home.

By the summer of 2000, Mr. Ryan was refusing medication, and his therapists considered hospitalizing him again. He asked to move from a room on the second floor to one on the seventh. The home agreed.

He told his social worker on Sept. 13 that he was afraid to get out of bed and was considering voluntarily going to a psychiatric ward, according to his treatment records. Two days later, at 7:20 a.m., the police said, he opened the window in his room and stood on the ledge. Then he jumped.

Less than three weeks later, Ms. Valante would follow. Her psychiatrist had also been considering hospitalizing her, according to her treatment records. Shortly after 8:30 p.m. on Oct. 3, Ms. Valante went to see her social worker, who had an office on the seventh floor, according to interviews and records. As usual after business hours, no one was there. She paced the hallway, then walked into a room, opened the window and jumped.

Vincent Sirangelo, Anna Erika's operator, said the home had done nothing wrong in caring for the two.

When asked for evidence to show that the home had been closely monitoring Mr. Ryan and Ms. Valante or had even known that they were in crisis, he declined to provide any. He said Anna Erika "had fulfilled its obligations."

"We did our own internal investigation," he said. "There was no reason that surfaced why they committed suicide."

The Ryan and Valante families heard nothing from state officials after the suicides, and got only a single phone call from Anna Erika administrators.

"They said, 'We just wanted you to know that your daughter is dead,'" recalled Ms. Valante's mother, Gertrude. "Just like that. I went out of my mind when it happened. And they wouldn't give me any answers."

Threat to Others
A Stabbing Ends A Rebuilt Life

Gregory Ridges, 35, called his mother every morning from Park Manor, a storefront home on Coney Island Avenue near Prospect Park in Brooklyn. He loved to tell her that he was setting off for his part-time job as a custodian. "I'm going to make the doughnuts!" he would exclaim, riffing on that old television commercial. Then he would put on his uniform and shoes, which he had carefully laid out the night before.

When he returned to the home he would let his mother know that the doughnuts had been made, a routine she cherished. Once plagued by paranoia about himself and his family, her son had slowly gotten better. He was one of the few adult home residents who held a job, and he took great pride in it.

The first boy of 10 siblings, Mr. Ridges had a special place in his mother's heart. She called him Big G, and loved his sense of humor. So did workers and residents at Park Manor, a home for 62 mentally ill people.

In the late 1990's, Mr. Ridges lived there with two other men in a dusky room not much bigger than a sleeper on an Amtrak train. He and Sanford Lall got along. Their other roommate, Erik Chapman, had an obsession with knives and threatened to kill them both.

Mr. Chapman was as feared around the home as Mr. Ridges was liked. One worker refused to be alone with him. Other residents recalled violent outbursts when he used illegal drugs and rejected his psychotropic medication.

Even his family was afraid of him. Before going to Park Manor, he stabbed his sister and stepfather, beat up his brother and attacked his father-in-law so viciously he was in the hospital for weeks. Psychiatrists had noted Mr. Chapman's violent tendencies, yet he was accepted at Park Manor in the mid-1990's and stayed for four years.

If people like Ms. Valante and Mr. Ryan did not belong at adult homes because they were a threat to themselves, Mr. Chapman exemplified a different sort of danger.

The screening of residents can be lax at the homes, in part because it is at the discretion of operators who have no mental health training and are running commercial enterprises. Since an empty bed means no money, some homes are willing to accept almost anyone, records and interviews show.

As a result, fighting among residents and other violence in the homes are not uncommon. Killings are, yet when they have occurred, they have gone unexplored. In 1989, for example, two women were killed in separate cases at Leben, and their deaths were not classified as homicides for months. The crimes were never solved.

At Park Manor, everyone immediately knew who the killer was. What went unexamined was why he had been able to remain at the home despite ample evidence that he was dangerous.

Mr. Chapman, now 33, began having psychotic episodes in the early 1990's while living with his family in Brooklyn. "He used to always carry a knife and brass knuckles," said his brother, Charles Chapman. "Was I scared of him? Most definitely. He just likes to physically attack you."

In 1994, after stabbing his sister, Erik Chapman was hospitalized at Kings County Hospital Center. "Patient remains very guarded and evasive," a psychiatrist wrote in his records. "This together with history of violent assaultiveness suggest he is a risk and dangerous to others." Less than two months later, Kings County discharged him.

From 1996 through 2000, Mr. Chapman lived at Park Manor. After one psychotic episode in late 1998, he went to Maimonides Medical Center, where psychiatrists repeatedly noted his hostility toward his roommates and his refusal to return to the home, according to his treatment records.

"Admits to possibly wanting to hurt men," a psychiatrist at the hospital wrote. Asked on a form whether Mr. Chapman had homicidal tendencies, another psychiatrist wrote a question mark and then, "Suggested hurting his perceived persecutors." Among his delusions: he believed his Park Manor roommates were coughing up blood on him.

After two months at the hospital, he was discharged back to Park Manor. Soon after, inspectors cited the home's operators for doing almost nothing to examine his psychiatric history or address his needs, according to a June 1999 state report. But the inspectors never followed up.

That was not out of the ordinary. As with other homes, inspection reports portrayed Park Manor as in disarray, to no avail. At one point, they noted, a college student was volunteering as the home's case manager for all 60 or so residents.

It was a testament to Mr. Ridges that he had been able to turn his life around there. He arrived at Park Manor in 1994 after several psychiatric hospitalizations. After a shaky start, he settled in. In the last year of his life, he focused on everyday issues such as how to budget his paycheck -- his doughnut money, he called it -- so he would not spend it all at once.

But he did have to contend with his roommate. His mother, Hattie Fee Ridges, said that her son often complained that the home would not do anything about Mr. Chapman. Mr. Ridges told her that he had asked for his room to be switched, but had been turned down.

Mr. Lall, their other roommate, said Mr. Chapman often instigated arguments with him and Mr. Ridges. Mr. Lall recalled in an interview how Mr. Chapman once shoved him against a wall and held a knife to him. "He said, 'If you don't behave yourself, I'm going to kill you,' " Mr. Lall said.

On a Thursday in June 2000, Mr. Ridges returned from his job and went to his room. He encountered Mr. Chapman and the two apparently argued over rap music, the police said. Mr. Chapman pulled out a brown and gold folding knife. He lunged, stabbing Mr. Ridges more than 20 times in the neck, sternum and arm.

"Me and Greg Ridges didn't get along," Mr. Chapman told the detectives who arrested him.

When Mrs. Ridges did not receive her customary phone call from her son that day, she called the home. An employee told her everything was fine. Wary, Mrs. Ridges went to the home that night, and no one would let her in. Several hours later, police officers showed up at her apartment and told her what had happened.

A few days later, she locked the door to her son's former room in her apartment. To this day, she rarely enters it. "I just can't bring myself right now to part with his things," she said recently. "I miss him."

Nearly two years after the killing, no one in an official capacity has delved into the home's role. Not the State Health Department, which regulates the home, nor the police, nor the Brooklyn district attorney's office, which focused only on prosecuting Mr. Chapman, who was found unfit for trial and sent to a psychiatric facility.

Otis Cue, Mr. Chapman's stepfather, said that he felt great sorrow for Mr. Ridges's family and that he hoped some lessons could be learned that might help prevent violence at the homes. But Mr. Cue added that no officials had contacted him about his stepson's history.

For now, there are only denials.

Park Manor's operator, Simon Halpert, said Mr. Chapman had no history of violence, was well liked at the home and had never caused the slightest trouble. "Anybody and everybody who comes in this door has had a thorough screening," Mr. Halpert said.

He said Mr. Ridges had never asked to have his room changed.

Maimonides Medical Center, which treated Mr. Chapman during his last hospitalization, said it never discharged patients who were a threat.

The only state agency saying it looked into the killing was the Office of Mental Health. It did so, it said, because therapists who worked at a clinic run by the office treated Mr. Chapman at the home. The office said it agreed with Mr. Halpert. It would not release a copy of its investigation, saying it was protecting the privacy of the mentally ill.

"We never had a problem with him in his behavior," Mr. Halpert said of Mr. Chapman. "He was very polite, always polite."

Casualties of Care
Ignoring the Signs Pointing to Trouble

On a spring Sunday in 2000, Ann Marie Thomas began to die at Elm-York, a 286-bed home tucked away near a ramp to La Guardia Airport.

Ms. Thomas, 60, was having chest pains and trouble breathing, according to interviews and records, and the workers there told her to relax. The next day, a nurse who visited the home told Ms. Thomas she was having an anxiety attack. By that night, the vice grip around her chest had tightened.

"She kept saying, 'I can't breathe, I can't breathe,' and clutching her chest in pain," said Terry Lipiro, a resident of the home at the time. Several workers confirmed her account.

Until then, Ms. Thomas had been relatively sturdy, the home's hallway Ann Landers, a gush of gossip and advice. Her delusions quelled by medication, she grasped at a normal life, doting on a boyfriend named Harvey, ordering in Chinese food and listening to Elvis Presley.

On Tuesday, Ms. Thomas saw a medical doctor, Mathaiah Ramaiah, who also diagnosed anxiety, and Ms. Thomas received no treatment, according to interviews and records.

"She had these chest pains, and they should have paid more attention to her," said Dhandai Dhanraj, a worker at the home at that time.

By Tuesday night, a roommate, Elizabeth Szalkiewicz, became alarmed and called Ms. Thomas's sister for her.

"I think I'm having a heart attack and they don't believe me," Ann Marie Thomas told her sister, Josephine, on the phone. "I think that I'm dying."

Josephine Thomas said she then called employees at the home, who assured her that her sister was fine.

A short while later, Ann Marie Thomas lay down on the floor of her room and removed all her clothes, hoping to find relief from the sensation that she was suffocating, according to interviews with residents and workers. Ms. Thomas stayed there, naked, and began to feebly pray.

The next morning, Ms. Thomas was found dead of heart failure, still in the same undignified position.

In interviews, executives of Elm-York said workers had closely monitored Ms. Thomas and reported that she was not in distress. They would not say which workers, or provide records detailing when they checked on her. "If there had been chest pains, 911 would have been called," said Robert Amsel, the home's administrator.

Mr. Amsel said the home provided such good care that "less than 10" residents died from 1995 through 2001.

The Times documented roughly 110 deaths of Elm-York residents in that period, largely from death records kept by the Social Security Administration.

After being given a list of those names, Mr. Amsel said that many of them were of people who were no longer residents when they died. He would not say which people he was referring to.

Dr. Ramaiah would not comment.

Josephine Thomas complained to the State Commission on Quality of Care for the Mentally Disabled, the small watchdog agency. She charged that her sister would have lived had she received proper supervision.

Thirteen months later, without interviewing her, the agency told her that it could find no evidence that the home had done anything wrong or that Ann Marie Thomas had ever complained of chest pain.

The commission might have found some evidence if it had examined the report filed by the ambulance workers who responded to the home. "Patient's roommate states that patient collapsed last night, 12 hours ago, but no one at the facility responded to her calls for help until this a.m.," the report said.

In a way, Ms. Thomas's death underscores the most basic shortcomings in supervision and care found by The Times's investigation at many of the homes. Yet she was certainly not alone. John Miller and Randolph Maddix were just two more residents who died unattended after signs of distress were ignored, records and interviews show.

Mr. Miller, 47, a resident of Park Inn in Queens, died of a ruptured gangrenous appendix in 1997 after complaining of pain for three days, according to his brother. The state took no action; his family is suing the home in State Supreme Court in Queens, charging that neglect led to his death. The home's lawyers would not comment.

At Seaport Manor in Canarsie, Brooklyn, even the untrained workers realized that Randolph Maddix was too sick to be there. During his two years at Seaport, ambulances took him to Brookdale University Hospital and Medical Center more than 40 times after he had seizures at the home, according to hospital records.

But whenever the workers said they suggested to the home's administrators that he be sent to a nursing home, the administrators demurred. It would mean an empty bed. And profits always

seemed to trump other considerations at Seaport, which the state has long rated one of the city's worst adult homes.

Less than a year after Mr. Maddix entered Seaport, a therapist wrote in his case file that he should be placed in a "more suitable environment" because he was paranoid and refusing to eat.

State inspectors also suspected that Mr. Maddix should not be there. In an inspection report in July 1999, they cited the home for failing to address his problems and send him to a facility with a "higher level of care," but did nothing else.

So Mr. Maddix stayed, and suffered. On several occasions, workers said he had seizures while watching television in the smoking room, then writhed and tumbled to the floor. He broke his elbow. He smashed his face. He bloodied his eye.

"He couldn't do anything on his own," said Andy Cadet, a former Seaport worker. "As time went by, the seizures started increasing, and getting worse and worse."

Seaport's operators would not comment. Last year, after The Times began an investigation of Seaport, the state said it would move against the home, even though it had known for decades about grievous problems there. Last month, the operators agreed to surrender their license, and the state is now considering whether to try to install a new operator or close the home.

Mr. Maddix had had seizure disorder since he was a teenager. One of the few things that gave him pleasure was smoking cigars and drinking coffee on the Coney Island Boardwalk as he stared at the water. But for much of his life, he could barely function.

He occasionally had an aide assigned to him at Seaport during the day, but the aide left before dinner. He was then deposited in his room, where he sometimes suffered seizures alone, in the dark. His roommate, who was partly blind and often delusional, sat by, unknowing.

"There wasn't anybody there at nighttime to watch out for him," said his mother, Mildred Maddix. "There wasn't anybody. Just him and God."

His last visit to the hospital was on Oct. 9, 1999. After a seizure, he was found unconscious in his wheelchair. Dried blood from a finger-length laceration crusted the right side of his face. As always, he was returned to the home.

Less than two weeks later, he went to the bathroom connected to his room in the early evening and had another seizure, falling between the toilet and the bathtub, workers said. He was discovered dead the next morning still next to the toilet.

At Seaport, the discovery of a dead resident was almost routine. The usual practice was followed: the home reported only that Mr. Maddix was found unresponsive and then pronounced dead, never telling the state the full details of what had happened.

As with the deaths of so many other mentally ill residents of adult homes, the state never investigated anyway.

The New York Times

Here, Life Is Squalor and Chaos

By CLIFFORD J. LEVY

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It was the fall of 2000 and state inspectors were due to arrive at Seaport Manor, an adult home for the mentally ill in Canarsie, Brooklyn. Upstairs, some of its 325 residents, bewildered and mumbling, shuffled along the dreary hallways. Downstairs, a handful of workers hastily doctored records, they said, to make it seem as if the home was providing proper care.

The workers said they concocted case notes for manic-depressives who holed up in their rooms for so long they became malnourished. They invented psychiatric evaluations for residents who went untreated and turned suicidal. They scrawled therapy plans for women who prostituted themselves in the stairwells for cigarette money and for men who shook down other residents for their $4-a-day allowance.

"We were told by the administrators at the home to be creative," said one worker, Toshua Courthan. "We were told we had to, or else we would lose our jobs. What the state wanted to see was that these people were being looked after, but they were not."

Ms. Courthan was fired after reporting the falsifying of records and other misconduct at the home to the state, and she is suing Seaport. Her account was independently supported by other current and former workers, including two who participated that evening, as well as by an examination of some of the records.

The inspectors who showed up that day in 2000, however, apparently never detected the hundreds of sham files, according to state records. Seaport, which receives more than $3.5 million annually from the government, stayed open. For its residents, life has remained as wretched as ever.

Occupying a one-acre tract, the five-story brick building sits behind a row of shrubbery at 615 East 104th Street, not far from the neighborhood piers. A generation ago the home, along with dozens like it, represented a briefly entertained hope for the thousands of mentally ill people being pushed out of state psychiatric hospitals. In these homes, residents would learn to live independently and enter a mainstream community.

Just how profoundly that vision has collapsed can be appreciated in words from the state itself, which dubbed Seaport "The New Warehouse for the Insane" in a 1997 study by the Office of Mental Health. If the state gave Seaport a cynical nickname, though, records show it did nothing meaningful to improve or police it.

A portrait of life inside Seaport was gleaned from more than 10 visits, more than 500 pages of state inspection reports and government documents obtained by The New York Times, as well as more than 50 interviews with workers and residents.

During a typical visit to the home, residents can be seen sitting for hours in the crowded smoking room, rocking back and forth, speaking only to themselves. Others can be spotted walking to the local liquor store, much to the dismay of those at the nearby day care center.

Current and former workers said two residents openly deal crack from their rooms, contributing to the drug abuse, loan-sharking, prostitution and violence that have gripped the home for years. In this predatory atmosphere, the frail quickly learn that the safest place is behind the closed doors of their rooms. Others find different ways to get by.

"It's tough around here," said a resident in her 50's who said she sells sex to workers and other residents for a few dollars. "You have to do it to survive."

Ambulances are regular visitors. In a three-month period last year, they made 93 runs to the home, city records show, sometimes to take away the dying, other times to rescue the neglected.

For years, workers said, a security guard subdued psychotic residents by beating them. Other employees are convicted drug dealers, prison records show. Several former workers said the home sometimes continued to collect the monthly disability benefits of residents after they died, or gave their Social Security numbers to illegal immigrants the home hired.

There were dozens of numbers to choose from. From 1995 through 2001, one Seaport resident died roughly every month, according to an analysis by The Times. In all, at least 79 died, including at least three who committed suicide and two others whose bodies were discovered only after workers were drawn to the smell of decay.

"This is the last stop," a resident named Jerry said in his room at the home. "They are not preparing anyone for living outside of here."

For 26 years, the state has documented problems at Seaport and then averted its eyes. Since 1998, conditions have been so bad that inspection reports concluded that Seaport, as one said, "was in serious noncompliance in all major areas of operation."

The reports cited inadequate staffing and dangerous lapses in the distribution of medication. During a 1999 inspection, investigators refused to fully examine rooms because they were so fetid. They also remarked in their records how workers at the home were able to walk past disheveled residents without even noticing them.

Only in recent months, after The Times began an investigation of Seaport by requesting government records and questioning officials, did the state say it would crack down on the home.

Its response, however, has been erratic.

Last August, the state said it would try to revoke the operators' license. Last month, it agreed to let them surrender their license, pay a $20,000 fine and close the home. But in recent days, the

state, confounded by the prospect of finding new housing for the residents, indicated it might try to keep Seaport open by installing new operators.

For now, the residents remain in Seaport under the same operators who the state has known for years have run a home of squalor and neglect. In 2001 alone, at least 18 residents died, The Times's analysis shows, 10 of whom were under 60.

Seaport's operators -- Baruch Mappa, Martin Rosenberg and Emil Klein -- said through their lawyer they would not be interviewed.

Before agreeing to surrender their license, the operators asserted in a disciplinary hearing before the State Department of Health that the home had undertaken renovations, overhauled medication practices and brought in more workers to increase supervision of residents.

"Seaport doesn't take the violations or alleged violations lightly," Ronald J. Aranoff, the home's lawyer, said at the hearing.

Over the years, Seaport, like many other adult homes, has often complained that the state has asked it to take responsibility for some of the most needy people while failing to provide enough money for their care. About 15,000 mentally ill adults live in more than 100 adult homes in New York.

The Department of Health said it did not take more aggressive action against Seaport in previous years because it preferred to help troubled homes improve conditions.

"Closure of a facility is disruptive to patients and residents, especially the elderly or mentally ill, and is typically pursued as a last resort after a home's repeated failures to comply with state regulations," said Robert R. Hinckley, a deputy state health commissioner.

The failures of Seaport can be witnessed in varying degrees at other adult homes in the city. State inspection reports on many of the homes are grim and interchangeable. Even so, the state seems to have grown accustomed to slapping the homes with one hand and shielding them with the other.

For the people who still live at homes like Seaport, most of whom are too sick to grasp the notion that they are entitled to something better, life is about doing what they can to endure.

Ritual Turmoil
Monthly Heightening Of the Daily Disorder

Residents and workers at the home call it payday. Once a month, Seaport's administrators hand out about $120 in allowance money to each resident from the disability checks they control. Then the pandemonium begins.

In-house loan sharks chase residents down the hall, intent on collecting their money, according to numerous current and former workers and residents. They said two crack dealers also opened for business, packing in an assortment of fellow residents, and even the police said they have made drug arrests at the home in recent years.

Those residents unwilling to take part in either enterprise run to their rooms, fearful of the opportunistic and desperately in need of their tiny allowances. Inevitably, the strong at Seaport always know when the weak are in line to get their money.

"It would be just one big mess," Angela Peters, a former housekeeper and dietary aide, said of payday. "We couldn't do any work on the floor because it was so crazy."

From the outside, Seaport looks like a decent alternative to the homelessness that defines another portion of the city's mentally ill. From the inside, based on visits to the home and extensive interviews, it does not. If a coed prison for the mentally ill were to exist, the inner workings of its yard might resemble Seaport. Except the prison would have security and a professional staff.

Ideally, the home is supposed to act like a bridge, helping the mentally ill return to neighborhoods where they can attain some self-sufficiency. In reality, there is nothing rehabilitative about the place -- it rarely tries to help residents obtain proper therapy, job training or, at times, even get dressed, according to state inspection reports and interviews with workers and residents.

There is never enough staff, and administrators and workers typically have no mental health training. The state does not require it at adult homes, though their residents are deeply troubled.

According to the 1997 state mental health study, of about half of Seaport's population, more than 80 percent had histories of multiple psychiatric hospitalizations, 35 percent had histories of violent behavior, 32 percent had abused drugs and 13 percent had attempted suicide.

"It's just too sad a place to go to work," said Sherry Reiter, a social worker who was assigned in the late 1990's to a clinic in the home run by the Kingsboro Psychiatric Center. "The sadness and the violence are part of the milieu."

Left with little supervision or treatment, residents often have psychotic episodes, records show. One man tried killing himself by taking an overdose of Tylenol, burning himself with hot water and then hanging himself with a pajama top coiled into a noose. A delusional woman repeatedly stabbed herself on the back and legs.

Newcomers to the home quickly learn there is little to do. The most popular spot is the smoking room -- a cluster of worn benches, bare walls, a television (always on) and a floor littered with cigarette butts, spilled coffee, ashes and discarded food.

The recreation room could offer other possibilities, but rarely does. For much of 2001, it was closed because there was no one to run it, workers and residents said. At other times, a high school student served as recreation director. For these schizophrenics and manic-depressives, the student liked to hold screenings of "Face/Off," a violent action movie about changeable identities.

In the late 1990's, a report by a state watchdog agency, the Commission on Quality of Care for the Mentally Disabled, rated Seaport one of the worst adult homes. Yet in 1997, the state awarded Seaport $41,501.25 in bonus money intended for homes that provide quality care, state records show. The state allocated the money largely for computer training for residents. Seaport does not have computers for residents.

It barely has a laundry room. The home had a single washing machine during one inspection, and it showed. Residents had "dirty, stained or ripped clothing" and were in need of a bath or shower, the inspectors wrote in their 1999 report.

The wait to receive psychotropic medication is sometimes half an hour or more, so some residents do not even bother. The ones who do are lucky if they get the correct pills, state inspection reports show. Peering into medication boxes, one inspector encountered dead cockroaches.

Andy Cadet, who ran the medication room for several months last year until she resigned, described the consequences of the chaos. "People were getting ill," Ms. Cadet said. "It was just a disaster."

The home itself does not provide psychiatric services, but it is expected to ensure that residents obtain them, either from the Kingsboro clinic at the home or from other psychiatrists who periodically visit. But the clinic, staffed by a psychiatrist and a few other trained workers, writes prescriptions that go unfilled. It asks that fragile residents be closely watched, and they are not, according to interviews with clinic workers and their records. The home's administrators, meanwhile, have long accused clinic workers of not doing their jobs.

At nights and on weekends, the residents are largely on their own. The clinic is closed, and the home has almost no one on duty. "Nobody wanted to take responsibility for patients who went berserk at night," said Louis Rossetti, who worked as a nurse at the clinic from 1980 until 1996 and then as a volunteer. "We would come in the morning and have to go upstairs and calm them down. It just over all got worse and worse."

Ms. Courthan, Ms. Cadet and several other workers said a security guard, Lionel Harrington, used to beat residents to subdue them. For his part, Mr. Harrington said he only tried to crack down on the drug-dealing, loan-sharking and prostitution.

He said the administrators at the home knew about the goings-on, especially the crack-dealing by one of the residents. "They are well aware that this man is destroying the residents in that building," Mr. Harrington said. He said he was fired late last year after he was late for work.

Toward the end of the month, as residents start to run out of money, the atmosphere in the home turns even worse, workers and residents said. Used condoms can be found in the stairwells and hallways, as both male and female residents trade sex for spending money, drugs or cigarettes.

"Generally, it was sex for drugs or sex for money," said Angela Johnson, a former worker at the home. "If someone wanted a dollar, it was sex for a dollar. Sex for anything was a big problem."

History
Hospital Emptied, Its Troubles Relocated

In the early 1970's, Kingsboro Psychiatric Center in Brooklyn, one in the state's array of vast mental hospitals, began aggressively emptying its beds as New York undertook the process of what came to be known as deinstitutionalization.

Kingsboro was looking for places to relocate its patients when Mr. Mappa, a local real estate developer, was looking for another business enterprise. His brainchild was to open Seaport Manor in September 1975 and take in many of those who were being cast out of the hospital's wards.

Only three miles from Kingsboro, the new building had a kitchen, dining room, recreation room and 13 bedrooms on the first floor; and 40 bedrooms on each of the second through fifth floors.

The idea, shared by Mr. Mappa and the state, was that the home would make for a civilized alternative to Kingsboro. Mr. Mappa would also make money. Residents would sign over their monthly government disability checks for rent, and outside providers would pay fees to the home for the opportunity to treat residents.

Yet neither Mr. Mappa nor the two business partners he brought in had any mental health expertise. The money from the government never seemed enough, and the care that came to be provided by the medical professionals was never adequate.

As a result, a troubled psychiatric hospital was emptied and effectively recreated in a place even less equipped to deal with hundreds of seriously ill people.

In the late 1970's, Seaport was a focus of an investigation into adult homes by a deputy state attorney general, Charles J. Hynes, who is now the Brooklyn district attorney. A grand jury found that at adult homes in Brooklyn, the condition of residents "was permitted to deteriorate to unconscionable levels." Ultimately, no charges were brought against Seaport or its operators, and leading state officials brushed aside Mr. Hynes's damning portrait of the adult home system.

The state did make a few changes at Seaport, including opening a clinic in 1979, one run by workers who came over from Kingsboro. But over the years, the state has cut the number of clinic workers to roughly 8 from nearly 20, Kingsboro workers said.

For much of the past decade, the home -- with more mentally ill people than most psychiatric hospitals in the nation -- has been run by Esther Elizabeth Rosenberg, the daughter of one of its operators. Ms. Rosenberg, 47, graduated from Brooklyn College in 1990 with a degree in sociology and had little work experience of any kind when she took over the home, according to court records and interviews.

The state has essentially called her incompetent. "The administrator is not capable of managing this facility and correcting the problems," a 2000 inspection report said. "We recommend enforcement be pursued."

But the state's own documented dealings with Seaport show that nothing much was done. It was not until March 2001, after years of incriminating inspection reports and concerns that residents were being neglected, that the state tried to discipline the home by levying a $7,000 fine.

But while it got Seaport to remove Ms. Rosenberg, it let the operators appoint her son-in-law, Seth Fried, as administrator.

The Workers
'I Knew Jack-Diddly About Medication'

It was clear that Toshua Courthan was in over her head.

She had no mental health training yet after only a short time at Seaport, she was promoted to case manager and then director of social services, playing a pivotal role in overseeing more than 300 chronically mentally ill people.

Over her two years at the home, she said, she was pressured to commit or she witnessed a startling variety of misconduct, from the forging of records to the misreporting of deaths. She decided in her second year that she could not keep silent, she said, and began secretly telling state inspectors about problems at the home. The inspectors took her calls, but otherwise seemed uninterested, she said. The state confirmed her calls.

In early 2001, Ms. Courthan, who is black, was fired, and she sued the home in Federal District Court in Brooklyn, charging that administrators had made racially insensitive comments to her. Aaron Charles Schlesinger, a lawyer for Seaport Manor, did not respond to three phone messages seeking comment. In court papers, Seaport denied Ms. Courthan's charges.

A review of inspection reports and interviews with more than 15 current and former workers support her account of life at the home. "Seaport's thing is, 'Let's fill the beds,' " Ms. Courthan said. " 'We don't care if they are psychiatrically unstable.' They don't care about these people."

Ms. Courthan was hired as a receptionist at Seaport in 1999. With low salaries and mismanagement, workers were constantly quitting, and she was rapidly promoted.

Her sister, Ms. Johnson, who had worked as a clerk for the City Board of Education, was later hired and put in charge of the medication room. Ms. Johnson found this strange, she recalled, because "I knew jack-diddly about medication."

Soon, Ms. Courthan and Ms. Johnson were helping to run the place, at $8 to $9.50 an hour. They received strong evaluations from administrators and were popular with residents, according to records and interviews, but were swamped with work. They were supposed to meet with residents monthly, file reports and ensure the residents were being seen by psychiatrists. But they rarely did.

This was obvious to state inspectors. In a January 2000 inspection report, they noted that of 30 resident files they had examined, 14 did not have current annual evaluations, let alone monthly case notes.

Later that year, the home was expecting another inspection, and Ms. Courthan and Ms. Johnson said Ms. Rosenberg, the home's administrator, told them to put the files in order, by forgery if necessary.

Ms. Courthan and Ms. Johnson said they and other workers stayed late one night and concocted hundreds of records, making up psychiatric evaluations and signing them with the names of fictional doctors. Ms. Cadet, the former medication worker, said she witnessed the forging.

By the time the night was over, records, some of which were shown to The Times, reflected that many residents had seen a nonexistent Dr. Rollins and received the same diagnosis. "Everybody, if you looked at their charts, they were all paranoid schizophrenic," Ms. Courthan said.

While state inspectors evidently did not detect that documents were being faked en masse, they had previously criticized the home's record-keeping, noting that files were "altered or missing."

Ms. Rosenberg would not comment.

Ms. Courthan and Ms. Johnson said the deception did not end with the forged records.

One night in November 2000, a resident named Dorothy Clinton set herself on fire and later died at the hospital. Based in part on interviews with Seaport employees, the medical examiner's office ruled the death an accident. The home contended she had ignited herself while smoking crack in bed.

Ms. Courthan, Ms. Peters, the former housekeeper, and other workers say the tale of crack smoking was wholly invented; they tell a different story. Ms. Courthan said she had recommended that Ms. Clinton be hospitalized that day because she seemed delusional and suicidal, but that an administrator had blocked the request.

That night, Ms. Clinton, 48, got dressed up, putting on earrings and makeup, and then intentionally ignited herself while in bed, residents and workers said.

Ms. Courthan said she wrote in Ms. Clinton's file the next day that she should have been hospitalized. When Ms. Rosenberg found out, she ordered Ms. Courthan to remove those notes, Ms. Courthan said. "Esther told me, 'If you speak to the coroner, and say anything about how depressed she was, it is going to be a problem for us and it will be a problem for you,' " Ms. Courthan said.

Ms. Clinton's death was one of the few the state has investigated at adult homes. But while it cited the home for having inadequate staffing, state records show, it does not appear that it addressed the question of whether Ms. Clinton had been suicidal and whether her death could have been prevented.

Three months later, Ms. Courthan was dismissed, and she said she tried to unburden herself to inspectors one final time. She faxed them a letter on Feb. 6, 2001, repeating and elaborating on many of her allegations. An examination of the letter shows she wrote of how she and other workers had forged the records, saying that they made up "those forms A to Z."

Again, she said, inspectors did nothing.

Asked about Ms. Courthan and Ms. Johnson, Robert Kenny, a spokesman for the State Department of Health, at first said that the two had talked to inspectors only in early 2000 and complained only about administrators' stealing money from residents. Mr. Kenny said the inspectors cited the home 18 months later for failing to manage residents' accounts properly.

Pressed further, Mr. Kenny acknowledged that the inspectors had talked to the two women more regularly and that they had received the faxed letter from Ms. Courthan.

He said her allegations "were not new to inspectors."

After Ms. Courthan was dismissed, the home had Ms. Johnson arrested and charged with stealing $200 from residents. She was fired. The charges were later dropped.

The Deaths
Invisible Lives End Without Notice

The final indignity for many of Seaport's residents comes with a shovel full of dirt at potter's field. Nearly one out of every four residents who died from 1995 through 2001 was sent to the island cemetery in the East River, without headstones to mark their graves or eulogies to recall how they weathered their troubled lives.

Seaport, after profiting from them, made no effort to find them proper burial. In a way, it was almost fitting, given that the residents' deaths came with the same invisibility that surrounded their lives at the home.

Of the 79 people who died in the seven-year period, the average age of death was 58. Twenty-four of the dead were under 50.

"People were dying like flies," Ms. Peters said. "They have nobody who is looking after those people."

It will probably never be known how many of the deaths could have been avoided. The home almost always either failed to notify the state about deaths or left out details pointing to deficient care, records show.

In turn, the State Department of Health could provide documentary evidence that inspectors looked into only three deaths at Seaport -- Ms. Clinton's and two others. Those three inquiries, in fact, were the only ones that appeared to have been done by state inspectors at 26 of the largest and most troubled adult homes in the city in the seven-year period, when at least 946 residents died, according to the Times's analysis.

Elayne Silverman, once a promising student who wanted to be a social worker, was only 39 when she took her life in April 1995 at Seaport. It was just after breakfast when she climbed the stairs to the roof, according to state records and interviews. No workers at the home noticed. Then again, it was a Saturday, and few were on duty. Either the alarm on the door to the roof was broken, or it went off and was disregarded.

Ms. Silverman walked around for a while before taking off her clothes, folding them into a neat pile and then jumping, according to a Kingsboro clinic record.

Even that failed to get anyone's attention. A neighbor eventually called the home and said a naked body was in the parking lot. When the clinic asked about the death, Seaport administrators could not explain how a home that sheltered numerous people with histories of suicidal behavior could allow such access to the roof, clinic records show.

The state never investigated her death, or those of numerous others, according to interviews and records: Stephen Willner, 60, who succumbed to dehydration and malnourishment in 1999; Lewis Howard, 45, who died of kidney failure last year after no one responded when he passed

out; and Albert Jarrell, 44, who had a heart attack in 1997 and was dead before workers thought to call 911.

While residents are free to come and go from the home during the day, the home is required by law to keep track of them. Bed checks are mandatory, but rarely done, residents and workers said. If a resident is missing for more than 24 hours, a report must be filed with the state and the police.

Artie Washington had not been seen for longer than that. Not only did Seaport not fill out a form, it did not even notice his absence.

Mr. Washington was known around the home for wearing an assortment of silly hats, from a Santa's cap to a Burger King crown. He was last seen on the Friday morning before Labor Day weekend in 1998. Early Monday afternoon, workers concerned by "a foul odor" entered Room 333, according to state records. "We found him dead, just sitting in the bathtub," said Mr. Rossetti, the nurse at the Kingsboro clinic.

An autopsy determined that Mr. Washington, 54, had died of a seizure. It is unclear whether he could have been saved had he been discovered earlier. Inspectors, in one of the three death inquiries they performed, criticized Seaport for allowing him to remain at the home even though he was unstable. Yet the state took no action to safeguard against similar deaths.

So in July 2001, Rosendo Velez, 77, was found dead. Mr. Velez, nicknamed Keebler because he walked like the elves in the cookie commercial, had returned to the home in a drunken fog, workers said. He was left in his room unattended anyway, and was found drowned an hour later in his bathtub, fully clothed. It was not until three months later, in October, that the state cited the home for failing to supervise Mr. Velez.

In the meantime, Martin Rochlitz, 51, was found decomposing in his sweltering room days after dying of a heart attack during an August heat wave, according to the coroner. Unlike the deaths of Mr. Washington and Mr. Velez, Mr. Rochlitz's did not even warrant a question by the state, its records show.

Holding On
Expecting Trouble, Fearing Even Worse

Kevin Johnson sees death all around him, and fears that his will be the next.

He has seizure disorder, schizophrenia and cerebral palsy. He is mildly retarded and cannot perform basic arithmetic. At a recent lunch, he had difficulty pulling the wrapper off a straw. Yet, sadly, even he understands that at Seaport, the odds are against him.

Mr. Johnson, 39, cannot forget all the seizures that have sent him tumbling to the floor of Room 106 during the past three years. Dazed and bruised, he is eventually found by a worker and taken to Brookdale University Hospital and Medical Center.

Each time, Mr. Johnson is admitted to the hospital for a few days. In vain, it calls the home for his medical and psychiatric history. "They could not provide more information on the patient," a nurse wrote one day. As always, he is sent back to the home.

His latest wound is a jagged gash on his forehead. He needed stitches to close it after banging his head on the floor during a convulsion. Still, he considers it a minor injury.

What he dreads is a repeat of what happened on a Sunday morning in July 1999. He was left alone to shower, had a seizure and passed out. It is not known how long he lay there as he was scalded by water that inspectors have repeatedly warned is too hot. He needed two skin-graft operations to heal huge swaths on his chest, back and arms.

Seaport never notified the state about his injuries, as was required, and Mr. Johnson was once again returned to the home. Left to himself, he has devised his own way of dealing with the seizures. "I sit on the bed and try to take it easy," he said the other day.

Ill since he was a teenager, Mr. Johnson is 5-foot-8 and beefy, with a mustache, a round face and no family. He has a kindly disposition, but often reverts to long silences, as if he learned long ago that the way to make it through the day is by shutting everyone out. He sits in his room for hours, listening to oldies on the radio and worrying that if he walks around the home, someone will harass him for money, or worse.

With the turmoil over Seaport's fate, Mr. Johnson's future is uncertain. For now, he soothes himself against his surroundings by reading the paperback King James Bible that he hides in the top drawer of his dresser.

Sitting on his flimsy mattress as mice scamper by, he opens to the same chapter and mouths the words, over and over. Second Corinthians, Chapter 5: Do not despair, for there is a better place in the afterlife.

The New York Times

Voiceless, Defenseless And a Source of Cash

By CLIFFORD J. LEVY

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The vans pulled up at the Leben Home for Adults in Elmhurst, Queens, collecting the mentally ill residents who had been led outside and told to take a seat. Among them were Robert Dowling, who communicates in half-sentences and twitches; his roommate, Robert Fazio, who cannot bathe or dress himself; Seymour Levine, stooped and unkempt; and Gail Barnabas, so depressed she sometimes does not speak.

None of them resisted, as if they were being chaperoned to a movie or a ballgame. The doors closed and the vans headed for the offices of a doctor who billing records show had never examined some of the residents, but who was about to perform a variety of eye surgery on them.

The scene would be repeated throughout 1999 and 2000, a few residents at a time. In all, the doctor conducted nearly 50 operations on more than 30 residents, the billing records show.

"So many people were having the eye surgery, it was like it was a catchable disease," recalled Peter Peterson, one of the more alert Leben residents.

Few of the residents had been complaining about their eyesight, and their general physicians had not noted problems with it, according to Leben workers and medical records. Neither the ophthalmologist, who had built a substantial practice around adult home residents, nor Leben notified their families.

The procedures, which ranged from cataract operations to laser surgery and required local anesthesia, cost the government more than $25,000, the billing records show. To this day, most of the residents cannot explain what was done to them, or why. Then again, having spent much of their lives in institutions, most are used to not asking questions.

The State Department of Health, which regulates adult homes, did not learn of the eye operations until they were uncovered by The New York Times. The department is now investigating them.

Ever since New York began closing its psychiatric wards in the 1960's and essentially replacing them with adult homes, the for-profit residences have become magnets for schemes that exploit the mentally ill, a yearlong investigation by The Times found. The investigation drew upon thousands of pages of billing and medical records and state files, as well as more than 200 interviews with workers, residents and family members.

Those interviews and records show that at several homes, what little money some residents have is simply stolen by the operators. At dozens of homes, residents are brought before a swarm of outside providers for treatment -- from surgery to allergy shots -- that seems more intended to generate revenue from government programs than to improve residents' well-being.

The State Department of Health, in fact, knew well before the eye operations that doctors might be taking advantage of residents at Leben, long one of the state's most notorious adult homes. In early 1998, department officials began investigating a complaint, later substantiated, that two doctors had coerced 24 Leben residents into having unnecessary prostate surgery.

Yet the department's records show it otherwise ignored the home, and did not increase oversight or take precautions to safeguard the people who lived there -- or at any other adult home, for that matter. In the regulators' absence, at least eight Leben residents who had had the prostate surgery then had the eye procedures, according to billing records and interviews.

The Health Department would not comment on its investigation of the eye operations. The ophthalmologist, Dr. Shaul Debbi, would not comment, citing the privacy of his patients. Leben's operator at the time, Jacob Rubin, would also not comment. He was removed by the state in May 2001 after The Times published two articles about malfeasance at the 361-bed home.

As with so much else involving adult homes for the mentally ill, this was not the way it was supposed to be. The homes, conceived as a decent alternative to the dead-end misery of the state psychiatric hospitals, were intended to give the mentally ill a chance at lives in which they might have jobs, receive better care and join society in an authentic way.

Instead, The Times's investigation shows, many of the homes have become another universe in which the mentally ill are taken advantage of and poorly served.

On one side are the homes' operators, a group of businessmen who include a disgraced lawyer and a state senator's husband who went unpunished by state officials despite stealing money from residents, court records show. On the other side are the providers, which include hospitals and doctors with tarnished state records. One nonprofit group, which offers psychiatric therapy to residents, even took the opportunity to use more than $1 million in government payments to engage in risky stock trading, according to its tax records.

In the middle are thousands of vulnerable people. Nearly all the residents can legally sign consent forms, and persuading them to do so is not hard. Workers at several homes said that if residents do refuse to see doctors or other providers who have financial arrangements with the operators, administrators threaten to hospitalize the residents or to withhold their spending money, which is typically entrusted to the homes.

"We would usually tell them, 'You don't see the doctor, you don't get your allowance,'" said Velma McFarlane, a former Leben worker. "I had to do that. I'm not lying. It makes me feel bad, but that was the policy."

Some residents undoubtedly require an array of services. Studies have shown that mentally ill people suffer higher rates of heart disease, diabetes and other ailments. Some may also be resistant to care that they genuinely need.

Yet at virtually all the 26 homes The Times examined, workers and residents spoke of coercive tactics aimed at dubious needs. While residents often go without proper psychiatric or medical care, they are paraded before allergists, vocational therapists, dermatologists and podiatrists, among others.

The government should not be shocked that the system is rife with seeming abuse and waste. The way in which the state set up the homes all but invited it.

The state decided it would pay the homes a small daily sum -- still only $28 per person -- to feed, shelter and supervise the residents. The fee is taken from the residents' monthly Social Security disability checks.

The homes were to bring in outside health care providers. The operators, who have long complained that the state pays them too little, quickly learned they could make significant money by charging rent or fees to the providers. In return, they guaranteed a bountiful supply of patients. Or the operators could start side businesses, like van services that residents are required to use to go to clinics or doctors' offices.

The fees are then billed to Medicaid or Medicare, which pay for services for the poor and mentally ill. Federal and state agencies rarely question the fees, and on average, along with disability payments, spend $40,000 annually on each resident, according to interviews and billing records. For the 15,000 mentally ill people in adult homes in New York State, that comes to $600 million a year.

The evidence of fraud and waste has not entirely escaped state officials. The mental health commissioner, James L. Stone, described in a December report a "layering of services" in some adult homes that had led to excessive costs. His office oversees the mental health providers who treat residents, though not the homes themselves.

But neither his agency nor any other arm of the state government -- including the Department of Health, the Legislature and the attorney general's office -- has made efforts to investigate or revamp the system, according to state records and interviews. Asked what it was doing to safeguard adult home residents, the State Department of Health could point only to a recent crackdown on part-time medical clinics across the state, some of which are in adult homes.

Robert R. Hinckley, a deputy state health commissioner, said the department had refused to renew the licenses for 50 such clinics in adult homes statewide, and delayed approving licenses for an additional 23. "The disapprovals of part-time clinic applications for adult homes were based on quality of care concerns and the potential for Medicaid fraud," Mr. Hinckley said.

Perhaps even more surprising than the state's limited response is the utter lack of one by the federal government, which shoulders an enormous portion of the more than half-billion-dollar-a-year industry.

Through disability payments, Medicaid and Medicare, the federal government essentially supports the adult homes. Yet in 30 years, it has rarely if ever examined their finances or moved to protect the civil rights of the people who live in them.

Danielle Grush, a spokeswoman for the New York office of the federal Centers for Medicare and Medicaid Services, said the office was concerned about abuses in the homes, but she could offer no examples of inquiries into them.

"There is an enormous amount of public money that goes toward supporting the people living in these homes," said Clarence J. Sundram, a former chairman of the Commission on Quality of

Care for the Mentally Disabled, a state watchdog agency. "But they end up living in wretched conditions."

The Surgery
Eye Procedures By the Vanful

Workers at Leben still recall the peculiar sight: Mentally ill residents walking down the labyrinthine corridors of the home during 1999 and 2000 with their eyes bandaged or covered by dark sunglasses.

"They didn't warn me or anything," Robert Fazio, now 61, said of his eye surgery. "They just took me. And then he put a laser beam in my eye."

Dr. Debbi, who operated on Mr. Fazio, performed an assortment of surgery on the more than 30 Leben residents during an 18-month period in 1999 and 2000. Some had cataract operations, according to billing records, and others had laser surgery for ailments listed as glaucoma and retinal tears. Some residents had more than one procedure.

"He said it was cataracts, and if he corrected it, it would be beautiful," said Gail Barnabas, now 53. "We were all brought into the van on the same day. We were there from the morning until 4 p.m., and just made it back for supper. Everybody had it. The whole van was filled."

Because adult home residents are often profoundly sick, the state requires the homes to notify their relatives of any medical procedures. Yet in numerous instances, relatives of the Leben residents said they were never told of the surgery.

"I didn't know anything about it," said Henry Dowling, the brother of Robert Dowling. "I think that it was totally unnecessary. There was nothing wrong with him."

For his part, Dr. Debbi was required by the state to ensure that the residents, like any other patients, fully understood the procedures, including the risks, before they signed consent forms. But a number of relatives said they found it hard to imagine their mentally ill family members making an informed decision on their own.

Ms. Barnabas's sister, Barbara Casali, said Ms. Barnabas "never really complained about her eyes. I was very surprised when she said she was having a cataract operation. I said, 'You're kind of young to have it.' And she said, 'Well, the doctor says I need it, so I had it.' "

Cataract surgery is rare for someone Ms. Barnabas's age. And she was among at least three Leben residents in their 50's to have such a procedure, according to interviews and billing records.

A cataract is a cloudy or opaque area in the lens of the eye. In the surgery, the lens is replaced with a plastic implant. Many ophthalmologists say that the surgery should generally be considered only when cataracts impair quality of life. Many people with cataracts need only corrective lenses.

It was not just people from Leben who were being shuttled to Dr. Debbi's office during the 18-month period. He also performed roughly 70 procedures on residents from three other adult

homes, according to billing records: Ocean House and Wavecrest in Queens, and Parkview in the Bronx, which have a total of 379 beds.

In two brief telephone interviews, Dr. Debbi would not comment. "I would prefer not to cooperate -- why should I?" he said. "I prefer to keep my practice private and my patients' care private."

Jeffrey Edelman, whose family runs the Parkview and Wavecrest homes, praised Dr. Debbi. Mr. Edelman said he "would have no reason to believe that the surgeries were unnecessary. Dr. Debbi is as far as I know a very trustworthy individual."

After The Times uncovered the eye procedures, a group that represents adult home residents, the Coalition of Institutionalized Aged and Disabled, filed a complaint last July with the Health Department, seeking an investigation of Dr. Debbi and the surgery.

Most of the residents who had the surgery continue to live at the home, which is under new management and was recently renamed Queens Adult Care.

Kurt Trentmann, who is one of the more lucid residents, said he had told a Health Department investigator that his cataract operation had made his vision worse, and that Dr. Debbi had not responded when he told him about complications.

"I told Debbi that I was having problems with my eye, that everything was distorted," Mr. Trentmann, 55, said. "He says, 'This is going to take time.' Well, it's been over two years now. And I haven't talked to him since."

Mr. Trentmann has switched to doctors at a Veterans Administration hospital, who told him that Dr. Debbi had implanted the wrong lens, according to his treatment records.

Others, like Mr. Dowling, 59, have no memory of the procedures. Dr. Debbi performed four operations on Mr. Dowling in four months, two cataract operations and two laser procedures, according to billing records. Dr. Debbi received more than $3,000 from Medicaid and Medicare for his services. Other costs for the four procedures totaled $2,500.

Those eye procedures were just a few of a lengthy list of services for Mr. Dowling that numerous providers billed to Medicaid and Medicare. From 1998 through the first half of 2001, the services cost roughly $150,000, even though Mr. Dowling had no serious physical ailments, the billing records show.

Among the fees were $70,000 for therapy sessions and nearly $20,000 for van services to take him to appointments, the records show. During this time, Leben would not fix a broken lock on Mr. Dowling's door, his brother said, and his clothes were stolen.

The Operators
Tainted Records And Family Ties

In 1991, a resident at Brooklyn Manor received $45,626 in retirement benefits, a veritable windfall in the world of adult homes. The money was entrusted to the home, and its operator, Benito Fernandez, took every penny of it, according to multiple reports by state inspectors.

It was not an isolated case. Throughout the early 1990's, state inspectors cited Mr. Fernandez and his associates for mishandling or misappropriating residents' money, as well as for poor conditions and supervision at the 216-bed home, in East New York.

Based on the inspectors' findings, the State Department of Social Services, which regulated adult homes at the time, refused to renew Mr. Fernandez's license. In 1996, an administrative law judge upheld the decision, citing overwhelming evidence.

The department had won, yet its senior officials soon withdrew the case against Mr. Fernandez, who is married to State Senator Nellie Santiago of Brooklyn. In addition, the senior officials rebuked the inspectors, taking away their authority over the home and giving it to inspectors based on Long Island. The records in the case contain no explanation for the state's reversal. State officials, repeatedly questioned in recent months about the case, would also offer none.

After the department withdrew its case, two nonprofit groups that represent adult home residents -- MFY Legal Services and Disability Advocates -- sued the department to force it to revoke Mr. Fernandez's license, but lost the case on technical grounds.

"I always had a sense that calls were being made to the higher-ups and political pressure was put on them," said Ann Pegg Biddle, a lawyer for MFY at the time.

Mr. Fernandez still runs the home. He and his wife did not respond to requests for comment. Shortly before she was elected in 1992, Senator Santiago was an administrator at the home, but the state ordered her removal after charging she had falsified records to make it appear as if she had attended classes required for administrators.

Last year, after The Times began investigating adult homes, the Health Department, which now regulates the homes, returned Brooklyn Manor to the city inspection office's jurisdiction. It found the home in disarray and cited it for many serious violations, including inaccurate, incomplete or nonexistent records.

Mr. Fernandez and Brooklyn Manor are hardly distinctive. He is among several operators with checkered records, and his home is symptomatic of a system that is loosely regulated and licensed.

The operators do not need mental health training, and the state often fails to scrutinize their backgrounds. A 1999 audit by State Comptroller H. Carl McCall found the Health Department did not verify references and financial information submitted by applicants and did not seek to determine whether the applicants had criminal histories.

So, in addition to an operator like Mr. Fernandez, the state ends up entrusting the mentally ill to people like Beryl Zyskind.

In the early 1990's, Mr. Zyskind ran what is now called Ocean House, and was charged by federal prosecutors with stealing money from residents, including $120,000 in Veterans Administration benefits from one resident who was a Vietnam War veteran. Mr. Zyskind, who was also charged with bank fraud, was convicted and sentenced to 30 months in federal prison.

The state soon gave its blessing to a new boss for the 125-bed home. He was Mr. Zyskind's brother-in-law, Sherman Taub, a lawyer who had resigned from the bar after being accused of billing his law clients for $232,000 of his personal expenses, according to records from the Appellate Division of the State Supreme Court.

In December, the State Commission on Quality of Care for the Mentally Disabled issued a report on Ocean House that alleged a staggering array of violations. It said Mr. Taub had engaged in an elaborate scheme to siphon millions of dollars from Ocean House through improper mortgage transactions and other maneuvers.

It said a company co-owned by Mr. Taub's son, Jay, had received $420,000 in Medicaid payments by submitting improper claims for home health aide costs for residents.

The Manhattan district attorney is also investigating the allegations.

Ocean House is technically one of the few nonprofit adult homes in the city, but interviews and records suggest that Mr. Taub has run it like a profit-making entity.

Among the items obtained by the home in recent years, according to the records, were three Lexus luxury sedans, which cost at least $40,000 each. At the same time, residents were sleeping on soiled sheets in filthy rooms, inspection reports show.

In a brief interview about the commission report, Mr. Taub said, "I can assure you that every allegation in there is not factual and not true."

Ocean House's lawyer, Mel P. Barkan, acknowledged that Ocean House had paid for Mr. Taub's personal expenses. But he explained that such disbursements were subtracted from money that Ocean House, a nonprofit entity controlled by Mr. Taub, owed Mr. Taub.

Asked about Mr. Taub's credentials for running a home for the mentally ill, Mr. Barkan said: "I think that he has a very fine understanding today of what is required to treat these people as well as they can be treated. And I think that this home is doing a very fine job."

The State Department of Health was not aware of the allegations against Mr. Taub and Ocean House until they were brought to light by the Quality of Care Commission and Manhattan prosecutors. After the commission report was issued in December, the Health Department said it would try to revoke the home's license.

For now, Mr. Taub continues to run the home. The state has also not taken any action against Jay Taub, who runs a nonprofit adult home in Staten Island called Hylan Manor, even though he was implicated in the allegations against Ocean House.

The Providers
Thousands in Rent For Space Unoccupied

With vast amounts of government dollars available, the business of treating residents has attracted numerous players, from small practitioners to major hospitals.

A rare look at the financial arrangements between the homes and providers was offered by the Quality of Care Commission's report on Ocean House in December. Investigators determined that Ocean House reaped at least $185,000 in rent annually from five providers, including $120,000 from St. John's Episcopal Hospital, and lesser sums from two home health aide agencies, an internist and a podiatrist, the report said.

The investigators concluded that the hospital was paying for space that it never occupied, suggesting that the fees might have been kickbacks. One home health agency, Americare, paid $36,000 annually under a lease that included provisions for a waiting area in the basement and two parking spaces. None of them existed, the report said.

Ocean House responded by saying that St. John's had merely not used space it was entitled to under its contract with the home. The home said Americare did have the basement area, and that the parking spaces were on a grassy spot next to the home.

St. John's conceded it had rented space it did not use, but said it had not done so for "improper or fraudulent" reasons.

In looking into some of the services provided to Ocean House residents, commission investigators found that St. John's had billed Medicaid for $300,000 in clinic sessions for Ocean House residents that were social or recreational, not psychiatric, in nature.

For example, at an art group run by the hospital, residents colored on a sheet and had soda and potato chips. There was almost no conversation, and the session ended within 20 minutes, the commission's report said. The cost: $141 per person per session. At other times, residents were taken on trips to the mall and the movies, or sang songs.

St. John's said that it had done nothing wrong, but that it had changed its practices.

Others hospitals have also been accused of inappropriate billing practices. In 1999, in one of the largest Medicaid fraud inquiries in the nation's history, Staten Island University Hospital agreed to reimburse the state $45 million for improper billing practices, largely at clinics for adult home residents.

Groups that are nominally nonprofit have also been involved in scandals. Last year, the State Office of Mental Health closed down one, New Hope Guild Centers, which operated mental health clinics for adult home residents and others. The office charged that New Hope had expanded its services without approval, lied to cover up its violations and billed Medicaid for unauthorized services like biofeedback therapy.

This month, two New Hope officials were charged by the state attorney general with defrauding Medicaid of $9 million.

Other nonprofits continue to prosper from the homes.

New Horizon Counseling Center, which offers therapy and other programs for adult home residents, pays its executive vice president $315,000, according to its recent filings with the Internal Revenue Service. New Horizon has had such robust revenue from Medicaid, reaping

$4.5 million annually, that in the late 1990's it made the more than $1 million in high-risk stock trades. New Horizon says it no longer engages in such trades.

New Horizon's biggest competitor is New York Psychotherapy and Counseling Center, which had $8.5 million in annual revenue, also almost entirely from Medicaid, according to its tax filings. It paid its executive director and medical director $260,000 each, and spent $75,000 lobbying in Albany.

That revenue derives from the close relationships the two nonprofit groups have built with the homes' operators, workers said.

In 1999, for example, residents of Surf Manor in Brooklyn were told by the home that instead of attending a New York Psychotherapy program twice a week, they would have to go five days, even though they did not want to and social workers said they did not need to go that often. The change came about after the home's operator, Robert Lichtschein, set up a transportation service to earn Medicaid money by driving residents to a variety of appointments.

Mr. Lichtschein said the residents had not been pressured to go. "The caseworkers here tell them that it is to their benefit to go out to different programs," he said.

Muriel Dethomas, a former administrator at New York Psychotherapy, disputed that account. Ms. Dethomas said it was common for Surf Manor and other homes, as well as the clinic, to pressure residents to go to the program by telling them that if they did not, they would be hospitalized or evicted or would lose their allowance.

"What they did was force them to come," Ms. Dethomas said.

Eric Bettelheim, director of corporate administration at New York Psychotherapy, said he was not aware that residents had been pressured. He said some residents might be making up complaints in an effort to retaliate against the home.

"They might be trying to manipulate the situation," Mr. Bettelheim said.

Feet First
$50 to $75 a Session For Clipping Toenails

There is no evidence of a medical link between mental illness and diseases of the foot, but the amount of podiatric care in the homes might indicate otherwise.

Talk to dozens of residents at the homes, and most say the same thing: they are lined up at least once a month to see a podiatrist. The session lasts a few minutes at most, and the government gets the bill.

"They put your name on the list and then a nurse calls you in and tells you that you have to go to the doctor," said Eileen Marcus, 45, who has lived at several adult homes in the city, including Oceanview Manor and Seaport Manor in Brooklyn. "It's outlandish. My nails don't grow that fast. That's all they do -- clip my nails."

The cost is not insignificant, especially considering how little money is spent by the state to house, feed and supervise the residents. An examination of several residents' billing records shows that Medicaid and Medicare were paying $750 to $1,000 annually per resident just for podiatric care.

Posted on the door of the medication room at Seaport Manor one Friday last summer, for example, was the morning schedule for a podiatrist named Dr. David B. Fuchs. It was three pages long, with 137 names in all. Those who saw Dr. Fuchs each received a few minutes of his time at a cost to the government of up to $100 per person.

The amount of care for one resident is evident in the case of Ernest Nelson, a 46-year-old who until this month lived at Seaport Manor.

Between 1998 and the first half of 2001, billing records show, Mr. Nelson was treated for various conditions, including 19 times for dermatophytosis (otherwise known as athlete's foot), 7 times for ingrown toenails, 4 times for corns and calluses, 4 times for heel pain, 2 times for hammertoe and once for a sprained foot. In all, Medicaid paid more than $2,500.

Dr. Fuchs defended his practice. "We see maybe 15 or 20 patients in a morning," he said. "They need the care. They have corns, they have calluses, they have pain."

Mr. Nelson has a different take. "They are just trying to make money off of us," he said.

At Leben, numerous residents have been treated monthly by a podiatrist named Dr. Stephen Smirlock, whose license plate reads FOOTBIZ. Some residents saw him more than 40 times from 1998 through 2001, billing records show. Dr. Smirlock did not respond to three messages seeking comment.

Some adult home administrators said paying podiatrists $50 or $75 a visit to clip toenails was appropriate, even though state regulations say the homes should provide such basic care themselves.

"Cutting somebody's toenails can be extremely injurious," said Benay Phillips, who helps manage the Elm-York home in Queens.

Medical fraud investigators in New York have long been suspicious of the podiatric profession. In the late 1980's and early 1990's, so many podiatrists were punished for cheating Medicaid that the state attorney general's office had the entire profession severely restricted from the program. But podiatrists working in adult homes have found ways to get around the rules.

And the state has largely stood by, records show, even though its inspectors have come across clues.

At Seaport, they cited the home in January 2000 after discovering prescription podiatric creams in residents' rooms, a violation of rules that bar residents from administering prescription medication themselves. But the inspectors apparently never looked into why so many residents had the cream in their rooms in the first place.

Had the inspectors questioned workers, they would have learned that podiatrists had prescribed so much cream that the home was running into a problem.

It seems that there was not enough space left in the medication room to store the psychotropic drugs.

A Roll Call: Decrepit Rooms To Wrong Pills

As operators and providers profit from adult homes, state inspection reports show that many of their residents go untreated and unbathed. Here are excerpts of findings since 1998.

ANNA ERIKA

427 beds, New Brighton, Staten Island

Resident with dementia wore urine-stained clothes for three days. Another had lesions draining onto clothes that went unchanged for two days. Another hid in room for days without eating or bathing, and was not hospitalized. While inspection going on, workers completed long-overdue records. Many residents complained about getting wrong psychotropic medication. When pills were missing, workers borrowed from other residents' prescriptions. Resident hospitalized after receiving wrong pills. Worker flushed pills down toilet instead of distributing them.

BROOKLYN MANOR

216 beds, East New York, Brooklyn

Resident had old and new blood stains on face and body, and was filthy. Staff did not respond to emergency calls from rooms. One resident lost 54 pounds in a year; home did not determine why. Records were inaccurate, incomplete or nonexistent. Worker signed that she gave medication to all 200 or so residents at 9 p.m., when she was not on duty. Kitchen and many rooms infested with flies. Residents made to work as janitors and in kitchen, in place of employees. One resident in charge of home one evening.

GARDEN OF EDEN

202 beds, Bensonhurst, Brooklyn

Operator routinely threatened residents with eviction, verbally harassed them and demanded compliance with unlawful rules, creating abusive environment. Medication handling chaotic, with psychotropic pills given haphazardly and at wrong times. Resident vomited for two days, no one called doctor or family, or monitored her. Meals meager and unappetizing.

LEBEN

361 beds, Elmhurst, Queens

Rooms so decrepit that 60 residents evacuated. Security guards distributed pills. Incontinent resident wandered home with wet pants. No activities in home, numerous fire hazards. Many

residents "ill-groomed and malodorous." Workers "psychologically abusive" to residents. One resident burned in fight, another shot.

OCEAN HOUSE

125 beds, Far Rockaway, Queens

Rooms infested with cockroaches. Residents sleeping on soiled sheets. Kitchen floor rotted. Widespread hazardous conditions due to dilapidated home, ongoing renovations. Operator and son accused of embezzling millions of dollars from home and Medicaid. Serious deficiencies in medication handling and residents' hygiene.

PARKVIEW

134 beds, Olinville, the Bronx

Anorexic resident allowed to deteriorate so much that she weighed only 76 pounds and then died. Of 15 case management evaluations sampled, none completed. Numerous residents not receiving psychotropic medication. Workers did not know basic first aid. Resident refused to sleep in room because roommate harassed him and had history of violence.