DISTRICT COURT, ARAPAHOE COUNTY, COLORADO

DATE FILED
June 6, 2025 1:46 PM

AFFIDAVIT OF PROBABLE CAUSE FOR ARREST WARRANT

I, Investigator Erik Van Cleave, of lawful age and being first sworn upon oath, state that I have probable cause for believing that:

ZAINAB NAMALE
DOB: 09/03/1990

did commit the crime(s) of:

18-1-501	CRIMINAL NEGLIGENCE	F5
18-6.5-103	CRIMES AGAINST AT RISK PERSON	F5
18-1-603	COMPLICITY	F5

on/or between 05/08/2025, within Arapahoe County, Colorado, and as grounds therefore state as follows:

That this Affiant is an Investigator with the Arapahoe County Sheriff's Office, and that the following information was obtained by me personally and from the official records of the aforementioned office.

This Affiant is aware of the following information as it is contained in Arapahoe County Sheriff's Office Offense Report #AC25-0007118, which was written by Arapahoe County Sheriff's Deputy ERIK VAN CLEAVE, and was subsequently read by this Affiant. Information taken from this report has been paraphrased by this Affiant.

On 05/10/2025, I was assigned the case through an APS CARES referral from Sky Ridge Medical Center. The case revolves around an elder abuse allegation against:

VILMA MCGUIRE DOB: 10/10/1932

The incident took place at:

ORCHARD PARK HEALTH CARE
6005 S HOLLY ST
ARAPAHOE COUNTY, COLORADO

Upon being assigned to the case, I was notified that VILMA was in Sky Ridge Medical Center Hospital and had suffered broken bones in her left leg. I was advised that she was transported to the hospital via ambulance from Orchard Park. Once I was assigned to the

case, I reviewed the original report APS-0000330616, which provided little additional information beyond what I had been informed of. After reading the report documents, I responded to Sky Ridge Medical Center, 3rd floor, and attempted to speak with the victim. Upon arrival, I was notified by the nursing staff that she had severe dementia and that she would not be able to tell me how the incident happened. During my time with the multiple nursing staff members, they stated that she had a spiral fracture of the tibia/fibula on the lower left leg and that she was currently in imaging and would not be back for a while. I met with:

STEPHANIE TROWBRIDGE
ORTHO TRAUMA NURSING MANAGER

Who was in charge of the floor VILMA was assigned to? I asked her if the injuries that VILMA came to her floor with were consistent with the injuries stated in the report from Orchard Health Care. She said "no" and that the injury is a spiral fracture on the left leg, and a twisting motion would have caused that. The original report stated that VILMA was found sitting in her wheelchair, screaming for help in terrible pain, and that no one had seen her fall, and they do not know what happened.
On May 10, 2025, I responded to the Orchard Healthcare Center to speak with staff about the incident. Upon arrival, I contacted the front receptionist, identified myself, and asked if I could talk with a manager. The receptionist asked a female employee in the front office if she could find someone to assist me. As I was standing in the front lobby waiting, I commented on the yellow cake meal that the receptionist was eating. She said she couldn't eat it because she was so nervous. I thought this was odd, so I asked her why she was nervous. She said it was because the police were there. I was then contacted by an unknown female who emerged from the office with a cell phone in hand and informed me that the CEO was on the phone and wanted to speak with me. The woman holding the phone was visibly nervous, and her hand was shaking as she said on the speakerphone. The CEO introduced himself briefly and began to explain his involvement in the case. I had not mentioned the case or the reason I was at the facility to anyone, which was peculiar to me. The CEO was so audibly nervous and spoke so fast that I was unable to understand his name or what he was saying. I found the demeanor of all the staff at that time very peculiar to me. A few minutes later, after the phone call, the Director of Nursing contacted me:

TIFFANY BOWLAND,
DOB:12/15/1982
DIRECTOR OF NURSING

Upon meeting TIFFANY, she took me to the conference room to speak with her, and another RN joined us:

DANIELLE APALSCH
RN CHARGE NURSE

Once we entered the room and sat down at the conference table, I explained the investigation to them. As I spoke to them, I placed my BWC on the table to record the interview. This caused both parties to become visibly and verbally nervous. TIFFANY began to explain what had happened in the incident to the victim. She stated the victim was found by staff in her room, half in and half out of her wheelchair, screaming in pain. Two of the staff nurses placed a GATE belt on her and began to move her from the wheelchair to the bed. TIFFANY stated that the victim "planted her feet" on the floor as she was being moved. TIFFANY stated they believe this is how the injuries to the victim happened, but they are not sure. I asked her if the injuries to the victim were sustained in the facility, and she stated yes. At that time, RN Danielle interjected, stating that the victim is known for "planting her feet" on the floor when she is being helped out of a chair, which makes it more difficult to move her. DANIELLE also believes the possible twisting motion of the victim's lower body during the movement from the chair to the bed possibly caused the injury to the victim. TIFFANY stated the staff notified her about the incident, and the decision was made to have an ambulance take the victim to Sky Ridge Medical Center for treatment. This concluded the interview. I asked Tiffany to email me all the reports of the incident and to advise the CNA and the LPN nurses to contact me, as I needed to interview them as well. She stated that she would send all the above information to me as soon as possible. As the interview concluded, we all began to walk out of the conference room. Tiffany appeared to be very nervous, walking ahead of me. She was making a phone call as she walked and placed her hand over the mic of the phone, so I could not hear the conversation. Her demeanor was noticeably very nervous and suspicious to me.

On 05/10/2025, I responded to Sky Ridge Medical Center to speak with the staff who took care of the victim. I was suspicious of the DON's behavior and the statement she gave, and I wanted to see if the statement was relevant to the injuries sustained. Upon arrival at the 3rd-floor conference room, I met with the following:

MISSY GRIFFIN VICE PRESIDENT OF QUALITY,	KIMBERLY BURKE DIRECTOR OF PATIENT SAFETY
ERIK LUNG, M.D. CHIEF MEDICAL OFFICER	JACOB JARREAU PA-C
ED SZUSZEREWICZ ORTHO SURGEON	STEPHANIE TROWBRIDGE ORTHO TRAUMA NURSING MANAGER

Once in the meeting, I began telling them about what the DON stated and how the victim's injury happened. I told them the DON stated it happened as the nurses were moving the victim to the bed from the wheelchair, and during a twisting motion, the victim planted her feet on the floor, which caused the spiral break in the victim's lower leg. ERIK LUNG stated that the DON story does not match the injuries the victim has. Every other attendee noted the same thing: the injuries the victim sustained do not match the explanation provided by the DON. During the meeting, STEPHANIE TROWBRIDGE stated that the victim was in pre OP and getting ready to go into

surgery. She stated she would get the surgeon who would be operating on the victim and have him join the meeting. A few minutes later, STEPHANIE returned with SURGEON ED SZUSZEREWICZ. I explained the incident to him and the reason given by the DON for the injury. I also asked him if the injuries he saw on the victim matched what the DON had told me. He stated that the break was not a spiral fracture, and the TIB/FIB was broken in two places. He noted that the explanation of events the DON was giving did not match the type of injury the victim had, and that there was no way the injury happened while the victim was in a wheelchair. He explained that the injury is not a spiral fracture but a clean break of the TIB/FIB.

At this point, I felt I had a good understanding of the incident and received an answer from the Sky Ridge staff. I adjourned the meeting and returned to HQ.

On 05/16/2025, I scheduled interviews with the CNA, LPN, and the DON involved in the incident. At approximately 1400hrs, the first interview began with:

PATIENCE JACKSON CNA
DOB:01/01/1992

Once the interview started, I asked PATIENCE if she remembered the incident. She stated, "Yes," and began to explain to me what had happened. She said she was in the hallway when she heard the victim screaming. She ran to the victim's room and found the victim halfway in and halfway out of her wheelchair, which was sitting next to her bed. She stated the victim also had the bed remote control in her hand. She also noted that the victim's legs, especially her left leg, were injured as she was screaming for help. PATIENCE stated she grabbed the bed remote control from the victim and ran back out into the hallway to get more help. Once out in the hallway, she asked:

ZAINAB NAMALE LPN
DOB:09/03/1990

To assist the victim as they both returned to the victim's room. Once in the room, ZAINAB took the remote and raised the bed as it was sitting, pressing the victim's legs underneath the bed.
Once the bed was raised they observed something "poking" out of her left leg but did not know what it was. They maneuvered the wheelchair toward the bed, then performed a two-person assist lift with the patient and helped her into bed. She stated that the LPN had conducted a comprehensive assessment of the victim and informed me that this was a change in the victim's health status. ZAINAB left the room to get an RN supervisor, who returned with her. The RN assessed the victim, took X-rays, and then transported the victim to Sky Ridge Medical Center. She stated that she learned of the patient's injuries later that night. During the interview, I presented all the statements I had from the facility, but I did not have a report from the CNA. I asked her several times why there

wasn't a report from her, but she could not answer me. I wondered if there was sufficient staffing on the floor during her shift; she stated that there was. The interview concluded at that time.

Once the interview concluded, I met with:

ZAINAB NAMALE LPN
DOB:09/03/1990

The interview began at 1500 hours. I asked her if she remembered the incident with the victim; she said yes and that the Director of Nursing had interviewed her. I then showed her a written report from the incident and asked if it was hers. She read the report and stated that the report is hers, but some parts are hers, and some are not. I found this odd and asked her who the rest of the report belonged to or who wrote it. She stated she did not know. I then showed her a computer-generated report and asked if it was hers. She read the report and said it was her report. I asked her to tell me what happened that night. She stated she was passing meds at approximately 1800hrs and saw the victim in her wheelchair. She asked her how she was, and the patient said she was fine. ZAINAB continued to pass medication when she was approached by PATIENCE, and was asked to help her with the victim. Once in the victim's room, the victim stated she was in pain and wanted to go to bed. ZAINAB noted the victim's legs were beside the bed, not underneath it, and she was still partially in the wheelchair, sitting. She and PATIENCE got on each side of the victim, did a two-person lift, and placed her back in bed. ZAINAB noticed the small bump on her left leg. ZAINAB asked the victim what happened to her; the victim stated she did not know. ZAINAB rushed out of the room and asked another LPN, not an RN, and they both made a medical assessment of the victim. Once the second assessment was completed, Zainab called the DON and the on-call DR. She stated that the X-rays had been done, and an ambulance was called to the facility to transport the victim to Sky Ridge Medical Center.
ZAINAB stated they made her, and the on-call DR called family members, and the decision was made to send the victim to the hospital. I asked ZAINAB if there was an RN in the facility during the incident, and why they were not called to assess the victim. She stated she didn't call the RN because the victim was asleep and being sent to the hospital. I then asked her if they used a device when they moved the victim. She said they used a GATE BELT around her waist to move her. I asked her why that was not in her report; she stated she didn't know. I asked her about the Tramadol medication she gave the victim for pain, and if there was something in the room stating she was not supposed to have that medication. She stated no, there was nothing in the room telling her not to give that medication to the victim. I asked her if there was a whiteboard in the room and if anything was written on it, saying not to provide the victim with Tramadol. She stated she doesn't remember seeing any writing on the whiteboard telling her not to give the victim Tramadol. I asked her when she first saw the victims, were they under the bed or being crushed? She stated that they were not under the bed, but beside it, and were not being crushed. I asked if she wanted to tell me anything else, and she stated no, and this concluded the
interview.

On 05/16/2025 at approximately 1530hrs, I interviewed the Director of Nursing:

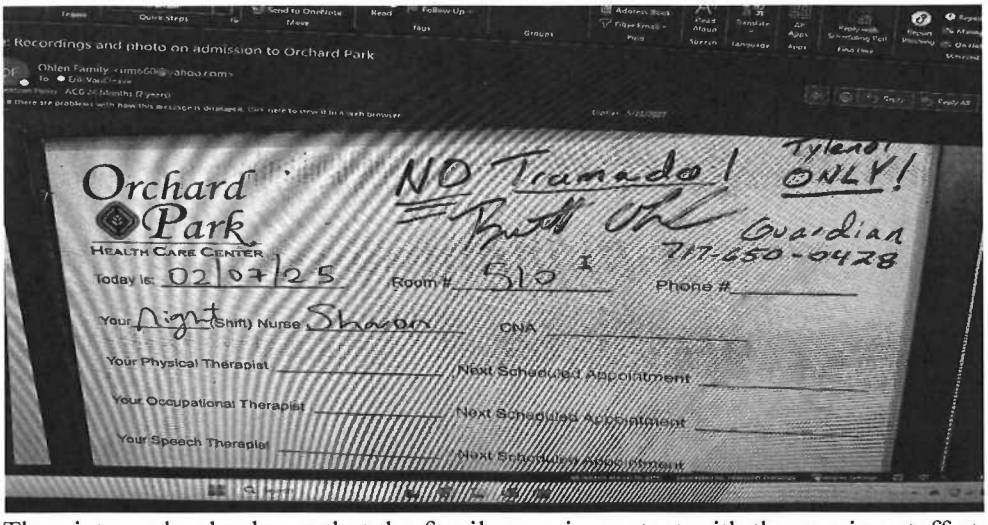
TIFFANY BOWLAND

I advised TIFFANY that I had the story of what happened and had a pretty good understanding of everything. I told her that I only needed to ask her some questions and fill in some holes about the incident. I began to explain to her that the first story she gave me during the first interview was completely different than the one the CNA and the LPN gave me, and that I had a lot of holes in the stories, and I was not understanding how the incident happened. She stated that during the first interview, she had limited information and provided me with all that she could at the time. She said that she can now provide me with the new information that has been brought to her attention. She stated that the following day, she began an investigation into the incident and got all the staff who were present during the incident to reenact what happened inside the room with the victim. She stated that written statements were done by the staff and reviewed by her. She then said she had the staff interviewed a second time by the facility administrator:

NICK SORENSON
ADMINISTRATOR

and new statements were written. I asked her so there is a second set of reports now? She state yes and began to tell me the same story the CNA and LPN had told me but added that the victim "wheels" around in the wheelchair and can move around in it. She also stated that the victim had her call bell on and was calling for help with it. She noted the victim's call bell light was only on for 3 minutes before the CNA arrived. She stated that when the CNA arrived, the victim had the call bell light and the bed remote control in her hands. I asked her about the medical record showing the victim receiving the drug TRAMADOL, and about the white board from the POA that said "NO TRAMADOL". She stated that she had not seen the whiteboard with the information from the POA and that they update the whiteboards every day.

The picture below is of the whiteboard in the victim's room, signed by the POA, not to give the
patient the drug TRAMADOL..



The picture clearly shows that the family was in contact with the nursing staff at the facility. I explained to her the seriousness of the case and that even after speaking with all parties involved in the incident, I still do not have an answer as to how the victim was so severely hurt with the SBI. TIFFANY stated she believes the bed, coupled with the victim holding the bed's remote control, did in fact cause the injuries to herself. I asked Tiffany if she had anything else to add.
She stated no, and I concluded the interview.

Once the interview was over, I returned to Sky Ridge Medical Center and met with the same medical staff as before. I explained to them the new story the DON gave me about the victim holding the bed remote control, pushing the lowering button, and having it come down and cause the injury to the victim's leg. CMO ERIK LUNG stated, No, there is no plausible way the bed came down with that much force on the victim's legs to create the substantial injury she has. He stated the bed does not lower far enough to have caused the injury. KIMBERLY BURKE noted that when the victim was in their care, she never pushed the nurse call light or grabbed the bed remote control once, because she has severe dementia and does not understand what a bed remote control is. KIMBERLY then took me to one of their patient rooms and demonstrated what Orchard Park stated had happened. Once in the room, she took the bed remote, raised the bed as high as it would go, sat in a wheelchair, and rolled it to the side of the bed. She then lowered the bed in an attempt to strike her outstretched lower legs. The bed lowered, but there was not enough of an angle between the bed and the floor to cause the injury stated by the DON at Orchard Park. KIMBERLY stated there is no plausible way the incident happened as stated by the DON. The demonstration was only a facsimile of the incident, as the bed and wheelchair were not the same as the ones used by Orchard Park. The demonstration was for clarity purposes only.

On 0521/2025, I visited Orchard Park and asked if I could see the victim's room and her bed. I was told to wait 45 minutes for the company's lawyer to arrive. Once the lawyer arrived, the administrator:

NICK SORENSON

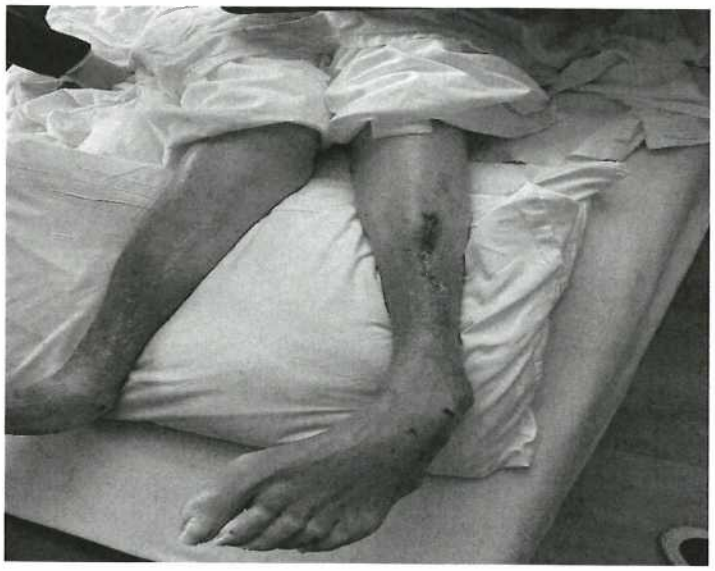
met with me and took me to the victim's room. NICK began to explain to me what he thinks happened to the victim as he sat down in a wheelchair that was next to the bed. He then rolled forward towards the bed. He then explained to me that the bed came down upon the victim's legs and caused the injury because the victim was a call light pusher and always had the call light and the bed remote control in her hand. I asked him to raise the bed and lower it as far as it would go. The bed was raised and then lowered to its full extent. I observed the bed at its lowest setting, and there was over 1 foot of clearance under the bed from the floor to the bed frame. I also observed the speed at which the bed lowered. The bed is an older model and has a speed slower than that of the bed used in the demonstration at Sky Ridge Medical Center. The bed lowered extremely slow. Once we were finished, I concluded the interview and left the facility.

On 05/30/2025, I received the surveillance footage of the incident from Orchard Park. I reviewed the footage, and it shows PATIENCE entering VILMA's room for a few minutes and then exiting the room to walk down the main hallway, appearing to be looking for someone. A few minutes later, PATIENCE and ZAINAB walked down the hallway and entered VILMA's room together. Soon after they entered, the video shows ZAINAB exit the room, walk down the hallway, and speak with an unknown second LPN as they both returned to the victim's room. The video only shows the unknown second LPN leave the room, and no other staff members enter or exit the room until the EMTs arrive and VILAMA is taken out of the room, placed on a pram, and transported to Sky Ridge Medical Center. The video is not time-stamped, but it clearly shows that only PATIENCE and ZAINAB were in contact with the victim at the time of the incident. The video does not show VILMA in the hallway, in a wheelchair, or being assisted by any other staff members.

As the investigation draws to a close, the victim is a 92-year-old elderly female with an SBI injury to her left TIB/FIB lower leg area. The injury was sustained at the Orchard Park Health Center, as stated by the DON, TIFFANY BOWLAND. The CNAs PATIENCE and ZAINAB were the only two staff members to be with the victim at the time of the incident. The explanation by the CNA, LPN, and the DON of how the injury happened to the victim is not plausible. All three suspects made statements to me that do not coincide with the evidence at hand. Sky Ridge Medical Center's medical staff also advised that the extent of injuries does not match the stories given by the suspects.

It appears that all three suspects are complicit in their actions to hide the truth of what occurred to the victim. As the victim's legs are turned inward, and she is not ambulatory, and requires a 2-person assistance to move, the injuries appeared to be caused by CRIMINAL NEGLIGENCE and is a CRIME AGAINST AN AT-RISK PERSON.

The picture below is of the patient's legs before the incident. The picture shows the victim's legs
turn inward, and it appears her feet are not able to sit flat on the floor or be able to "wheel around" in a wheel chair.



Therefore, this Affiant respectfully requests that an arrest warrant be issued for:

ZAINAB NAMALE
DOB: 01/01/1992

for the charge (s) of:

18-1-501	CRIMINAL NEGLIGENCE	F5
18-6.5-103	CRIMES AGAINST AT RISK PERSON	F5
18-1-603	COMPLICITY	F5

This Affiant has read the foregoing statement and the matters stated therein are true to the best of my knowledge and belief.

Erik Van Cleave, Affiant

SUBSCRIBED AND SWORN TO before me on this 4th day of June, AD 2025.

SHERRI C APODACA
Notary Public
State of Colorado
Notary ID # 20204003299
My Commission Expires 01-27-2028

Notary Public