Master Failure List (Expanded Detail)

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How to read this document
Each failure includes:
1. **What happened** (observable reality)
2. **Where it stemmed from** (origin/root)
3. **How it propagated** (why it became bigger)
4. **Examples observed**
5. **Business impact**

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1) Wrong role in field leadership (Doer vs Manager)

What happened
Field leadership often acted as high-effort doers rather than true site managers directing workflow, sequencing, and subcontractor accountability.

Where it stemmed from
Role design and staffing decisions placed people with strong work ethic but insufficient production-management capability into command positions.

How it propagated
Without command-level management, subs controlled pace and sequence by default. This created reactive execution, constant firefighting, and weak accountability loops.

Examples observed
- Ryan/Dyer period: high effort, low directional control over subs.
- Repeated “rescue” patterns instead of planned control.

Business impact
- Schedule instability
- Inconsistent quality
- Executive intervention required to restore momentum

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2) Third-party GC model reduced ownership urgency and focus

What happened
Bringing in third-party GC support did not create reliable control. In some phases, urgency and ownership weakened, and attention was split across their other jobs.

Where it stemmed from
Control authority sat outside owner-direct chain, with no guaranteed single-project focus and no strong internal enforcement layer behind GC execution.

How it propagated
When problems emerged, accountability diffused between owner side and GC side, slowing correction and allowing issues to linger.

Examples observed
- NWA crew stronger than LR crew, but third-party structure still caused delay/coordination drag.
- Farco role transitions and inconsistent follow-through.

Business impact
- Delayed decisions and execution
- Rework and duplicated effort
- Reduced confidence in delegated control

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3) Cross-project resource cannibalization (NWA rescuing LR)

What happened
NWA capacity was repeatedly diverted to stabilize Little Rock performance failures.

Where it stemmed from

Inadequate local supervisory strength in LR and lack of hard boundary policy preventing resource drain from better-performing jobsite.

How it propagated
Every rescue trip interrupted NWA sequencing, reset local momentum, and created rolling delays in both projects.

Examples observed
- Multiple LR supervisor failures
- NWA team repeatedly pulled off core scope

Business impact
- Double-project drag
- Lost production rhythm
- Preventable timeline extension

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4) Site plan change churn overwhelmed entitlement cycle

What happened
Rogers site plan was changed repeatedly (roughly seven times, with most changes running through city approval).

Where it stemmed from
Value-maximization strategy (higher unit count/project value) executed without strict late-change governance limits.

How it propagated
Each redesign triggered new engineer/city loops. Approval cycle time stacked, relationship friction with municipality increased, and downstream field work waited.

Examples observed
- Multiple full city re-runs
- City fatigue/frustration pattern

Business impact
- Entitlement delays
- Schedule push to construction and leasing windows
- Increased carrying cost risk

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5) Unit mix changes broke long-lead procurement alignment

What happened
Unit mix/layout changed after long-lead takeoffs were used for overseas procurement, causing mismatches when materials arrived months later.

Where it stemmed from
No firm lock gate between layout-sensitive design and long-lead purchasing commitments.

How it propagated
By delivery time, installed reality and ordered quantities/specs diverged, forcing domestic backfill purchases at higher cost.

Examples observed
- China shipments arriving against outdated layout assumptions
- Replacement sourcing needed domestically

Business impact
- Cost overruns
- Material waste/mismatch
- Delay from patch-procurement

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6) Arch/Structural mismatch at release point

What happened
Decisions and takeoffs were often based on architectural sets while structural sets lagged and later changed assumptions.

Where it stemmed from
Asynchronous design pipeline and no enforced conformance checkpoint before final release.

How it propagated
Framing package errors, missing required components, and late field corrections.

Examples observed
- Missing/incorrect framing-related small critical items (e.g., anchors, ties)
- Structural details diverging from earlier architectural assumptions

Business impact
- Field stoppages and rework
- Procurement inefficiency
- Confidence loss in release quality

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7) MEP plan drift after architectural revisions

What happened
MEP intent was not consistently synchronized when arch lighting/layout changes continued after initial handoff.

Where it stemmed from
Weak revision governance between Arch ↔ MEP, and field referencing outdated sets once work had started.

How it propagated
Electricians worked from stale assumptions; rough-ins no longer matched latest design intent.

Examples observed
- Can light/exterior lighting/wiring location changes not fully reflected in field sets

Business impact
- Electrical rework
- Schedule extension
- Increased trade friction

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8) Plan distribution failure at last mile (GC to subs)

What happened
Updated plans were sent to GC but did not reliably reach all trade crews in active zones.

Where it stemmed from
No enforceable acknowledgment chain and no “work-stop until receipt/understanding confirmed” protocol.

How it propagated
Crews continued building from superseded plans, especially after in-flight changes.

Examples observed
- Doghouse/dormer framing discrepancies
- Elevation/lighting/window color mismatches

Business impact
- Wrong work installed
- Replacement orders and delays
- Material and labor waste

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9) Schedule integrity failure

What happened
Schedules and human takeoffs repeatedly failed.

Where it stemmed from
Likely combination of software/workflow error and insufficient reconciliation QA before release.

How it propagated
Orders placed on schedule assumptions later failed fit/count reality.

Examples observed

- Rogers door jamb/frame depth mismatch requiring extenders
- Frame depth not matching wall depth at install
- Plumbing takeoffs were dependent on plumber-provided inputs and still came in wrong.
- Hangers had to be changed after framing changes were made after process start.

Business impact
- Rework and supplemental buys
- Cost and time loss at install phase

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10) Field tolerance errors not caught at framing stage

What happened
Built conditions were dimensionally off (clearances/offsets/openings), causing cabinet/appliance/finish conflicts later.

Where it stemmed from
Lack of in-field framing QA by highly competent supervision before dependent trades mobilized.

How it propagated
Preformed components (including overseas materials) no longer fit intended conditions.

Examples observed
- Door position too tight near refrigerator zone
- Cabinet/granite fit failures tied to rough framing variances

Business impact
- Rework loops
- Delay to finish trades
- avoidable change costs

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11) Trade standard nonconformance

What happened
Later siding crew used >2x trim vs baseline building and repeated misuse after correction. Lumber was also misused under a “grab what you see” mentality instead of controlled allocation.

Where it stemmed from
No hard baseline conformance and no stop-threshold when material burn exceeded standard.

How it propagated
Material exhaustion triggered emergency reorder and delivery resequencing.

Examples observed
- Same trim misuse repeated even after being shown benchmark building
- Wrong color/elevation execution despite formal change
- Lumber was pulled ad hoc (“grab what you see”) instead of by scoped install needs, causing overuse and avoidable shortages.

Business impact
- Additional truck rolls
- Delay to later buildings
- material and financing/lease-timing cost impact

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12) Municipal inspector variability created moving targets

What happened
Different inspectors preferred different methods; accepted work under one inspector could be challenged under another.

Where it stemmed from
No structured jurisdiction preference tracking and pre-clarification mechanism for interpretation-sensitive scopes.

How it propagated
Teams adjusted methods repeatedly, creating rework and planning instability.

Examples observed

- Building and utility inspection variability across both projects

Business impact
- Time/material loss
- schedule uncertainty
- increased inspection risk exposure

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13) Executive workload collapse into tactical operations

What happened
Executive and senior operators were pulled into overlapping tactical roles beyond intended scope. This was not isolated to Tracy: Dylan was carrying regional manager responsibilities while also acting as property manager across two projects and helping run day-to-day management company operations. Similar overlap pressure likely affected other leaders as well.

Where it stemmed from
Support layers (field supervision, accounting/admin reliability, delegated procurement quality) were not stable enough to absorb work, so urgent tasks repeatedly escalated upward to whoever could unblock them fastest.

How it propagated
As incidents stacked, executive-level roles were pulled into daily task ownership instead of being reserved for break-glass escalation. For Tracy specifically, scope expanded beyond intended responsibilities into recurring day-to-day execution that should be delegated, but staffing gaps and immature systems left no stable handoff path. This constant fire-fighting reduced the ability to maintain precision standards and increased error exposure through context-switching.

Examples observed
- Draw packet/check/waiver/notary/mail workflows consuming executive time
- Purchase correction loops after wrong orders by delegated parties
- Repeated ad hoc interventions by senior staff to keep field/admin workflows moving when ownership was unclear or execution slipped

Business impact
- Executive time consumed by recurring operational ownership instead of escalation-only leadership
- Slower strategic decision cadence due to constant interruption
- Greater risk of avoidable mistakes under sustained overload
- Burnout and single-point dependency risk
- Persistent delegation failure because staffing depth and system controls are not yet sufficient

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14) Trust deficit in first-pass deliverables

What happened
Inputs (plans, takeoffs, financials, counts) were often incomplete/inaccurate, requiring extensive re-vetting.

Where it stemmed from
Lack of first-pass quality standards, weak QA evidence at handoff, and inconsistent preparer reliability.

How it propagated
Decision cycles slowed, execution stalled waiting for re-validation, and micromanagement became survival behavior.

Examples observed
- Repeated need to independently verify submitted numbers and packages

Business impact
- Productivity loss
- leadership exhaustion
- persistent bottlenecks in execution flow

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15) Executive-level communication breakdown

What happened
Communication across senior leaders was fragmented: each person was doing meaningful work, but there was no reliable shared view of what had already been communicated upward, by whom, and when. Daily updates existed, but cross-visibility between leaders remained inconsistent.

Where it stemmed from
No single executive communication operating system existed to unify updates, ownership signals, and decision status across departments. Reporting channels were mixed (AI-assisted reporting, texts, phone calls, ad hoc updates), which created speed but reduced consistency.

How it propagated
Leaders spent additional time reconciling each other's status, confirming what had already been sent to ownership, and identifying gaps late. This created duplicate effort (do work + build report + cross-check peers), reduced speed, and increased misunderstanding risk. If executive communication quality is unstable, field-level communication quality predictably degrades as well.

Examples observed
- Unclear whether Dylan's and Zac's updates to Russ were sent, when they were sent, or what exact content was included.
- Significant time spent daily correcting report formatting while still needing separate texts/calls to align cross-department status.
- Fastest escalation channel is often still text/phone, but those channels are not automatically captured into shared continuity.

Business impact
- Executive coordination friction and duplicate communication effort
- Delayed decisions from uncertainty about current shared truth
- Inconsistent messaging to ownership
- Reduced ability to proactively plug gaps across departments
- Field communication suffers downstream when executive alignment is incomplete

Cross-cutting conclusion
These are not isolated misses. They form a recurring system pattern:
- uncontrolled change velocity,
- weak release/acknowledgment control,
- insufficient field QA gates,
- and overloaded executive intervention as the unofficial control mechanism.

Without structural controls, the same failures will recur regardless of effort level.