

Master Failure List (Expanded Detail)

Status: Private working draft
Date: 2026-04-25

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**

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.

Potential solutions

- Define role clarity in writing: manager directs and owns outcomes; doers execute tasks.
- Assign one Field Manager of Record per site plus backup.
- Run daily manager-led sequencing huddle with trade owners, blockers, and next-24-hour commitments.
- Use weekly manager scorecard (schedule, quality, escalation response).

Business impact

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

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.

Potential solutions

- No continuation of third-party GC model.
- Build and control your own internal team.
- Use an incentive structure with reasonable base pay plus milestone/time-performance commission.
- Tie incentives to measurable quality, schedule, and communication metrics.
- Create internal bench depth and succession coverage so control does not depend on any single external party.

Business impact

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

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

Potential solutions

- Set no-poach rule for core site resources unless executive-approved emergency.
- Define minimum staffing baseline per site before cross-project reallocations.
- Create surge bench plan so emergencies do not stall other jobs.

Business impact

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

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

Potential solutions

- Install hard late-change gate after design freeze.
- Require written value-vs-delay memo for late changes.
- Batch non-critical changes into planned release windows.
- Track revision count and entitlement-cycle impact weekly.

Business impact

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

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

Potential solutions

- Lock unit mix before releasing layout-sensitive long-lead POs.
- Split procurement into universal vs layout-sensitive buys.
- Maintain PO exposure register tied to revision status.
- Trigger mandatory revalidation whenever layout shifts.

Business impact

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

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

Potential solutions

- Enforce conformance gate: no release without coordinated Arch + Structural set.
- Close discrepancy log before procurement release.
- Run targeted pre-issue review for structural-critical items (anchors, ties, hangers).

Business impact

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

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

Potential solutions

- Issue coordinated revision packet listing MEP impacts and superseded sheets.
- No changed-zone work until updated MEP set is acknowledged in field.
- Require daily foreman version check for impacted scopes.

Business impact

- Electrical rework
- Schedule extension
- Increased trade friction

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

Potential solutions

- Maintain single Current-for-Construction register.
- Require acknowledgment chain from GC and each impacted trade.
- Apply no-acknowledgment/no-work rule in changed zones.
- Post active version physically and digitally at site.

Business impact

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

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.

Potential solutions

- Require schedule-to-elevation reconciliation before PO release.
- Implement takeoff QA checklist signoff at source.
- Adopt stronger takeoff platform (software and/or AI) that reads CAD and cross-checks Arch/MEP/Structural.
- Independently validate plumber-provided takeoffs.
- Re-run hanger and related material checks after framing changes.

Business impact

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

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

Potential solutions

- Install mandatory framing hold-point QA before release to dependent trades.
- Use critical-dimension checklist with photo evidence.
- Block release to cabinets/appliances/finishes without pass signoff.

Business impact

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

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.

Potential solutions

- Create standard-work baseline from first correct install.
- Allocate material by scoped need; eliminate open-pile grab behavior.
- Track daily burn-rate variance with stop/escalate thresholds.
- Retrain and re-certify crews after first major variance event.

Business impact

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

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

Potential solutions

- Maintain jurisdiction-specific inspector preference log.
- Run pre-inspection alignment for high-risk scopes.
- Seek written interpretation on ambiguous requirements.
- Add schedule buffer for interpretation-sensitive inspections.

Business impact

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

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

- 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

Potential solutions

- Reset executive role to escalation and decision ownership, not daily operational ownership.
- Move recurring transactional workflows to dedicated support roles.
- Set SLA accountability and staffing-change triggers for repeated misses.
- Protect executive planning windows from interruption except critical escalations.

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

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

Potential solutions

- Define first-pass quality standards by deliverable type.
- Require checklist-backed QA evidence at submission.
- Return submissions that lack QA evidence.
- Use trust tiers: full review until proven, then sample review.

Business impact

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

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.

Potential solutions

- Implement one executive update protocol (same format, cadence, cutoff).
- Maintain shared log/dashboard of what was sent to ownership, by whom, when.
- Allow urgent text/call escalation but require same-day logging.
- Run daily 15-minute leadership sync to close cross-department gaps.

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

16) What naturally improves in an indoor repeatable production model

What changes structurally

If production shifts to an indoor, repeatable manufacturing model with standardized components and controlled sequencing, several current failure drivers reduce by default. This does not remove the need for management discipline, but it changes the risk profile from variable field execution to controlled process execution.

Failures that naturally reduce or largely go away

- **Weather-linked disruption and resequencing pressure** drop materially.
- **Municipal inspector variability tied to in-progress field interpretation** is reduced where work is completed/verified before site install.
- **On-site tolerance drift** (framing variance, ad hoc fit decisions) is reduced through jigs, repeat setups, and controlled QA checkpoints.
- **Trade-to-trade scope confusion in open field conditions** declines because handoffs occur in a standardized line process.
- **Material misuse** ("grab what you see" behavior) declines with controlled kitting and inventory issue-by-scope.
- **Version confusion in active field zones** decreases when product revisions are released as controlled production versions.

Failures that remain (but become easier to control)

- Upstream **design-change governance** is still critical; uncontrolled late changes still create cost and waste.
- **Takeoff and BOM accuracy** remains essential; errors now show up in production runs if not caught early.
- **Executive communication and decision clarity** still matter; better process does not replace leadership alignment.
- **Staffing quality and accountability** are still required, but training is easier in repeatable systems.

Strategic implication

Moving to indoor repeatable production can remove a meaningful share of today's field-variability failures and improve schedule predictability, but only if paired with strict version control, disciplined change gates, and clear operational ownership.

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.