Department of Health & Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0391

Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 05D2140871	**(X3) Date Survey Completed** 08/20/2024
Name of Provider or Supplier Artius Dermatology Associates, Pc	**Street Address, City, State** 573 W Putnam Ave, Porterville, CA	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	**Summary Statement of Deficiencies**
D0000	THE LABORATORY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 493; REQUIREMENTS FOR CLINICAL LABORATORIES.